

Guardians of Care Humanization during the Pandemic: Child Neuropsychiatry Residents' Experience as Volunteers in Italian COVID-19-Designated Hospitals

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Guardians of Care Humanization during the Pandemic: Child Neuropsychiatry Residents' Experience as Volunteers in Italian COVID-19-Designated Hospitals

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Ethic approval: The institutional review board of the Ethics Committee in Pavia (IRCCS Mondino Foundation, Pavia) reviewed and determined this study to be exempt from further review and approval.

ABSTRACT

Objective. During the first months of 2020, the coronavirus disease of 2019 (COVID-19) has rapidly spread as an unprecedented pandemic. With the increasing number of hospitalizations, the resources of medical and nursing personnel needed for the direct and indirect care of patients were soon inadequate. Consistently, medical volunteers became a key human resource and young medical residents in any specialty were hired on a voluntary basis to contribute to take care of patients with COVID-19. This study reports on the lived experience of residents in child neuropsychiatry who volunteered in Italian hotspot COVID-19-designated hospitals during the epidemic outbreak.

Methods. A phenomenological, qualitative approach using semi-structured interviews with open-ended questions was used to obtain in-depth narratives of the experience of residents in child neuropsychiatry volunteering in the ***blinded*** hotspot COVID-19-designated hospitals. All residents (n=8) participated in the study. Interviews were conducted by an expert researcher trained in qualitative methods. Data analysis was performed by independent coders.

Results. Five core themes were identified: Playing as a two-fold mediator, Facing the shock of COVID-19 reality, Capitalizing from the own specialty education, Growing as persons and professionals, and Humanizing medical care.

Conclusions. This study is unique in providing an in-depth understanding of the experience of young residents in child neuropsychiatry volunteering in general hospitals during an unprecedented epidemic in Northern ***blinded***. The findings suggest that this experience may be highly beneficial for both the residents and the hospital quality of care. Insights for accurate planning of residents' engagement in future healthcare emergencies are provided.

Keywords: COVID-19; epidemic; phenomenology; medical education; medical residents; pandemic; qualitative methods; volunteering; neuropsychiatry

During the first months of 2020, the coronavirus disease of 2019 (COVID-19) has rapidly spread as an unprecedented pandemic [1]. The relative higher mortality rate of COVID-19 compared to other known coronaviruses and the higher contagion rate have resulted in a healthcare emergency worldwide [1,2]. Northern ***blinded*** – especially the ***blinded*** region – has been the first and most dramatically hit hotspot of COVID-19 emergency in Europe [3,4]. While intensive care units rapidly exceeded their patient saturation potential, the psychological impact of the epidemic emerged as a critical issue for healthcare professionals working at the forefront of the ***blinded*** emergency [5].

With the increasing number of hospitalizations, the resources of medical and nursing personnel needed for the direct and indirect care of patients were soon inadequate [3]. Consistently, the mobilization of medical volunteers became a key element during the COVID-19 outbreak [6]. Young medical residents in any specialty were hired on a voluntary basis to assist in different tasks, ranging from helping with direct intensive care actions to providing communication support with patients' caregivers [7,8].

Research to date is reporting on the psychological and mental health effects of COVID-19 emergency exposure in experienced and senior healthcare professionals, suggesting that a high proportion of these physicians and nurses will have to face post-traumatic stress symptoms [5]. Nonetheless, broader consequences of COVID-19 pandemic can also be traced in the medical training paths of residents enrolled in specialty programs [9]. Additionally, to the best of our knowledge, there are no reports on the medical residents' volunteering lived experience in COVID-19 designated hospitals.

In the present paper, we report on the findings of a qualitative phenomenological study conducted with child neuropsychiatry residents who volunteered in ***blinded*** hotspot COVID-19-designated hospitals. Such an in-depth appreciation of their

experience is key to capitalize from the present emergency and to inform clinical and policy plans for the involvement of medical residents in similar future events.

Methods

Study design and participants

In this qualitative study, a sample of Italian child neuropsychiatry residents was interviewed in depth about the core of their experiences regarding their volunteering activities in COVID-19 designated hospitals. Data were collected and analyzed based on the phenomenological methodology suggested by Colaizzi [10]. According to this approach researchers try to understand and to describe the subjective experiences of participants by recollecting the situation or event itself. In other words, the researcher uses discontinuities such as bracketing to describe participants' experience world without bias or prejudice. In this phenomenological approach, the situation itself refers to the subjective feelings, perceptions, and reactions experienced by the participants in a specific life situation. Accordingly, in the present study, Colaizzi's method of phenomenological analysis was applied - as the theoretical framework for this qualitative study - using semi-structured interviews with open-ended questions [11]. Participants were recruited through purposive sampling to identify “good informants,” that is, those who had experienced the phenomenon under study and were reflective and willing to share their experiences. Residents in child neuropsychiatry were consecutively and purposively recruited [12] at the Department of Brain and Behavioral Sciences of the University of ***blinded***. All residents serving as volunteers in hotspot COVID-19 hospitals were enrolled (see Table 1). All participants provided informed consent for the interviews. Confidentiality was assured by using numbers instead of names and removing identifying information from the transcripts. All audio recordings and transcripts were saved on a password-protected computer. Throughout

this study, we followed the Standards for Reporting Qualitative Research guidelines.

The institutional review board of the Ethics Committee of ***blinded*** reviewed and determined this study to be exempt from further review and approval.

Context

All the participants were residents in the specialty program in Child Neuropsychiatry of the University of ***blinded***. The Child Neuropsychiatry specialty lasts 4 years and it is aimed at educating young medical doctors in child neurology and psychiatry. Only postgraduate medical students can access this specialty. This specialty is specifically focused on at-risk development and child disability, it is informed by principles of medical rehabilitation, psychology and social sciences and it promotes a global and holistic approach to developmental neurology, psychiatry and rehabilitation. During the COVID-19 outbreak, the residents volunteered in three general hospitals and an emergency department where patients positive to the virus were hospitalized for intensive care therapies. The volunteering experience lasted from one to four weeks in the period from April to May 2020.

Procedures

The participants were interviewed using remote video-conferencing in June 2020, in respect of the norms for the mitigation and containment of the COVID-19. In order to elicit experiential descriptions from participants, we used a semi-structured in-depth interview guide to ensure consistent coverage of the topic under investigation. The interviewer reviewed the informed consent document, answered any questions, and, with the participant's written and verbal consent, proceeded with the interview. All interviews were conducted in Italian language, they were recorded and then transcribed verbatim. The interview guide is reported in Table 2.

Data analysis

The analysis was conducted on the Italian language transcripts and translation to English occurred only for publication purposes in order not to lose nuances of participants' original language. Data have been analyzed independently by three coders (*blinded for peer review*) using the Colaizzi phenomenological method [13]. In the first stage of the analysis, the researchers read the transcribed data several times, focusing on the context of the data and participant responses, and selected significant statements. Then, similar expressions were grouped and organized among the extracted statements, and they were reconstructed in a more abstract fashion. This was followed by the extraction of a theme by grouping similar content in significant statements, and similar themes were grouped and categorized into over-arching themes with high abstractness. Each coder independently read each transcript to extract significant statements and themes. Inconsistencies among coders were discussed and solved with a senior author who has training in psychology and extensive experience using qualitative research methods in medical education ****blinded****.

Descriptive phenomenological analysis uses thick description and close analysis of the lived experiences to understand how meaning is created through embodied perception and to capture meaning and common features. According to the descriptive phenomenological analysis theoretical principles, a continual effort was made by the coders to “bracket” preconceived beliefs, assumptions, and biases and avoid allowing personal perspectives from having an involuntary influence on the interpretation of the participants' narratives.

To ensure the rigor of this study, we start the interviews with open-ended questions and allowed participants to talk about their experiences freely in their own language. We also used bracketing to maintain neutrality excluding researcher's thoughts, experiences and emotions, and the same question was asked in different forms to allow repeated identification during interviews and analysis. Moreover, we mentioned the participants'

quotations so that the reader could verify the analysis of the data. Finally, we separately recorded the researchers' preconceptions and assumptions, on the topic of inquiry during the entire research process. Thus, the present findings reflect the experiences and opinions of research participants as much as possible, minimizing the prejudices of the researchers.

Results

Our sample consisted of eight Italian child neuropsychiatry residents who volunteered in four COVID-19-designated hospitals in the *****blinded***** region (*****blinded*****) between April and May 2020 (see Table 1). All the participants were involved in the management of patients diagnosed with COVID-19 in the hospitals in which they were volunteering. Thematic redundancy was achieved with the eighth interview and two participants were then interviewed to confirm thematic redundancy. Interviews lasted about 45-60 min.

- Insert Table 1 here -

Five core themes were identified: (a) Playing as a two-fold mediator, (b) Facing the shock of COVID-19 reality, (c) Capitalizing from the own specialty education, (d) Growing as persons and professionals, and (e) Humanizing medical care. Each theme will be discussed; quotations from participants are used to support the authors' claims, illustrate the results and illuminate on participants' experience.

Playing as a two-fold mediator

Participants reported that they were “useful” in some way, probably in a different way compared to the usual tasks they were involved in child neuropsychiatry units. Most of

all, they were involved in indirect care actions and they had to be ready to shift between different tasks:

«I was like a jolly, providing help where and when it was necessary» [ID04]

The indirect yet crucial role of residents volunteering in COVID-19-designated hospitals also involved the facilitation of communications. In a setting where the opportunities for communication were reduced to minimum (e.g., the patient was not capable of speaking and the urgent needs of intensive care implied a prioritization of actions over words), volunteers played as two-fold mediators or “relay racers”. In other words, they were the key personnel that made communications effective between the staff and the patients or the relatives as well as between the patients and their families. Here are some examples of communication facilitations that the residents made possible:

«I was important to help physicians and nurses in the daily rounds with patients» [ID08]

«I had to communicate with the patient’s relatives about negative news, even to communicate the death of their loved one» [ID02]

«I think that our job there was more like a complementary companion to the urgent care provided by physicians and nurses» [ID05]

The role played by the volunteering residents as facilitators of communications was further highlighted by their engagement in the management of patients’ belongings after death. The residents were involved with the intensive care unit staff in collecting personal belongings of patients and they tried to find ways to provide them to the patients’ relatives, closing a circle of empathy and family care.

Facing the shock of COVID-19 reality

By entering in a COVID-19-designated hospital, participants dramatically dived into the reality of the epidemic. The severity of patients' disease conditions and the impact on families emerged abruptly in the perception of volunteers:

«Before starting this experience, the news I received on COVID was quite impalpable, a bit like it could be for the rest of the population [...] let's say that I didn't distinguish myself too much from the population compared to the other doctors» [ID03]

Moreover, participants were well aware of the differences between their usual setting in child and adolescent neurologic-psychiatric units and this newly faced emergency medical context. Above all, the usual experience in pediatric units did not include the confrontation with themes related to death and end of life, which emerged as the most dramatic source of emotional shock:

«The most difficult part was when I had to communicate the death of this patient to his family» [ID03]

«When I had to manage the personal belongings of dead patients ... this was hard» [ID07]

«This was simply something I was unprepared to manage, both as persons and as professionals» [ID08]

The emotional shock connected with this experience was also exacerbated by the feelings of urgency and speed, which ultimately resulted in the perceived loss of control: usually

«There was no protocolled way to do this [...] too many factors were outside of the physician's control» [ID02]

«Even just a call that perhaps had not been seen as urgent and was postponed then risked failing to be made» [ID07]

Partially as a consequence of being suddenly exposed to such an emotional shock, residents' affective responses included feelings of fear and guilt:

«I felt like I was part of the [healthcare] system, I was not able to limit this emergency» [ID05]

«I was afraid of not being up to it» [ID01]

«Feeling guilty for the simple fact of being afraid, as if fear were not something that should have been granted or possible» [ID02]

While they were coping with these emotions, finding the right balance between empathy and self-regulation rapidly became a key aspect of their experience:

«Being able to manage emotions, without hiding them but also avoiding to become unable to contain them during the interaction with the patients or the relatives» [ID05]

«It was important for them to know that there was a physician who could understand how they felt» [ID06]

Capitalizing from the own specialty education

As the volunteers were residents in child neuropsychiatry, dealing with the intensive care needs of adult and elderly patients in an emergency setting was at first disorienting for some of the participants:

«I was used to working with infants and children and now we had to deal with old patients with severe conditions – it was like a shift of paradigm and I had to invent quite completely how to communicate with them» [ID04]

Nonetheless, the specificity of the specialty in child neuropsychiatry also appeared to be a facilitator for the transition to a different state of mind. These facilitators included the familiarity of concepts like patient-professional communication, empathy, family-centered approaches. Communication skills, in particular, are a key feature of the residents' curriculum, as most of their usual clinical practice consists of conducting thorough anamnestic and diagnostic interviews. For example:

«We are not surgeons, we are probably the specialty that you can define as less “medical” among all. It is intrinsic to our profession the study of how to improve the relational and psychological approach with patients and families»

[ID07]

«We tend to be a little more welcoming than maybe others [...] the other doctors I mean» [ID01]

Whereas the themes of death were something new and previously unexplored during their first years of practice, participants were able to capitalize from other experiences where the healthcare was not completely overlapping with healing, but with patient-centered care:

«For example, children with autism spectrum: you almost do not heal them in the common sense of this word. And this situation was similar: we were not there to heal but to take care of that situation, including both the patients and the staff. We were there to give the necessary help.» [ID07]

Growing as persons and professionals

Finally, the participants reported that this intense experience was a learning occasion for them, both as young professionals and human beings. The uncertainty and the unpredictable schedule of each day was a source of potential distress, but also allowed the volunteering residents to discover new resources and initiatives:

«I wanted to get involved, to put myself on the front line, to find the best strategies for doing it a little on your own» [ID05]

«Maybe in my future career I won't have many occasions, but this experience gave me some hints about how to manage emergencies – which is not the rule in my field, but sometimes it may happen» [ID01]

The intense emotional contact with the patients and their families was reported by some of the interviewed participants as a unique experience, that provided them with relevant emotional burden that could also be overwhelming:

«And she said to me the name of her daughter [...] and then crying, because she added “Who knows if I'll ever see her again” [...] A shocking moment, if you start to think that that can happen to your family, no one's safe» [ID05]

At the same time, facing such an emotional tornado was also a catalyzing experience to improve personal and emotional skills and capacities:

«I have always tended to be ashamed in my personal relationship, but also with parents [...] now I can feel that I am less concerned about this [...] this unlocked something emotional in me» [ID01]

Professional implications also were reported, highlighting the importance of clear and sincere communications with patients as well as the need of taking care of patients as persons and human beings and – using the words of the participants – “remaining human”:

«If you avoid giving bad news because you are afraid, you do your job wrong» [ID04]

«The challenges I had explaining to a patient with the C-PAP helmet that this was necessary for his health [...] Now I really know that communicating with patients calmly and clearly is part of this profession» [ID08]

Humanizing medical care

The participants were not involved in the direct physical care of patients. Rather, they engaged in indirect care actions, such as granting telephone contacts between the patients and their relatives, being the ones who gave feedback to the family about the health condition of the most severe patients, and providing emotional support to patients and their informal caregivers. A major theme that was highly redundant among interviews regarded the participants' feeling of being responsible to take care of the psychological and emotional well-being of patients, even during an urgent emergency in a highly technological and intensive curing environment:

«Patients simply asked us to bring a caress [...] So, in the end, even if she was not conscious anymore, I caressed her on behalf of her daughter [...] I could feel it was something we promised to each other» [ID05]

«Sometimes the physicians said to us: "If they are fine, don't waste time with them"» [ID02]

«I realized that we were there not just to take care of physical needs, but especially to pay attention to the emotional and personal needs of patients and their caregivers"» [ID02]

«Our aim was not to give clinical explanations or technical details, rather we were there to partner with their suffering» [ID07]

Residents were highly sensitive to the psychological conditions of patients and provided a psychological container for emotional and affective instances that otherwise would have been partially or completely neglected:

«Once a patient entered into the COVID unit, she disappeared from the rest of the world» [ID07]

«The most fragile leaves were falling, and no one was there to catch them before they reached the floor” [ID02]

The participants felt that taking care of these emotional and psychological needs was somehow complementary to the direct care provided by specialists in the intensive care units:

«It is difficult to be empathic when you have to completely focus on physical and medical care in the most severe patients, when you deal with survival [...] so I think I was useful, because no one was paying attention to this aspect» [ID03]

«We were like salt. Salt is not something necessary, but it is something that gives a taste to the experience, something enriching» [ID05]

Discussion

The main aim of this study was to identify core themes of child neuropsychiatry residents' experience while volunteering in COVID-19 designated hospitals in ***blinded***. First, volunteering residents were mainly involved in indirect care actions. They mainly perceived themselves as mediators of the communications among patients, their families and the healthcare professionals. In a sense, they were key to facilitate interactive exchanges of information and emotional contents in a setting where communication was impaired – for example, for the use of mechanical ventilation – and risked to be undervalued due to the severe patients' clinical conditions and the lack of

human resources caused by the sudden COVID-19 outbreak [14]. The volunteering residents provided support to communications between the staff and the patients – or their relatives. The availability of personnel with a medical background that serves this relational goal is of crucial importance in emergency settings as facilitating patient-professional communications may reduce the risk of errors in clinical decision-making [15,16]. This is meaningful as the facilitation of the interaction between the patients and their families reduces the risk of loneliness due to the forced separation and isolation they were living. Residents perceived providing such an empathic and affective support to patients and their families as a necessary activity, complementary to the direct medical care.

Although they were involved in indirect care tasks, the study participants unanimously reported that the experience of being in contact with patients diagnosed with COVID-19 made them suddenly and abruptly aware of the dramatic emergency. This emotional shock was mainly evident in relation to the perceived urgency of medical care as well as their direct exposure to the patients' death. Previous literature suggested that medical staff exposed to such events may exhibit detrimental mental health effects [17,18]. Recently, frontline professionals dealing with patients diagnosed with COVID-19, have been found to have high levels of stress and burnout symptoms and risk of post-traumatic stress disorder [19,20]. Consistently, although this negative psychological impact has not been explored in volunteering medical residents, the consequences of this emotional stress and burden in this population should not be underestimated.

Moreover, residents in child neuropsychiatry do not usually face the risk of death of their patients, which may present complex and chronic clinical conditions with low mortality rates [21]. From this point of view, volunteering in COVID-19-designated hospitals was a potentially overwhelming psychological experience for the residents, which responded with feelings of fear and guilt. They were afraid of not being prepared

and equipped to help with direct care and some of them felt guilty as part of the medical staff that only partially was able to face the rapidly increasing number of patients and the severity of their condition.

It should be highlighted that even during this unprecedented experience, the study participants were able to benefit from skills developed during their specific educational path. Indeed, all the interviewees reported that their specialty medical education provided them with specific relational, communication, and psychological skills. These included the approach to patients as human beings and the relevance of engaging families and relatives in clear communications [22,23]. From this perspective, the presence of residents in child neuropsychiatry in a COVID-19-designated hospital resulted in a positive and enriching synergy between senior healthcare professionals with critical care expertise and young medical trainees that brought in the attention to wider person-related needs.

Consistently, the study participants reported that this experience was invaluable for both their personal and professional growth. They highlighted how dealing with such an intense journey helped them find new ways of managing their own emotions and feelings in their relationship with the patients. They also reported being rewarded through a strengthened feeling of confidence in their own professional identity after this experience. Additionally, they gained even more reinforce for what pertains to the importance of investing in relational and emotional support with patients and their families.

Finally, the humanization of care was identified as an overarching theme in residents' narratives. The accent posed by interviewees on the role and relevance of empathy and human-to-human emotional contact during their attendance in COVID-19-designated units may be at least partially seen as a coping strategy to deal with the emotional reaction to this experience. Nonetheless, it is also evident that this attitude to the

humanization of care is also something implicitly inherent to the child neuropsychiatrist professional identity that the study participants were developing during their educational journey. Humanization of care – especially in an emergency setting – may be perceived as non-priority, as the survival of patients is at high risk and depends strictly on physical therapeutic actions [24,25]. Still, even in emergency settings, granting space and resources for the emotional well-being of patients and their families is necessary to support clear and open communications about the health status of the patient and to provide timely responses to the psychological needs of the informal caregivers [26]. The engagement of volunteering residents from other specialties may be a non-negligible resource to promote a skill-mixed effective partnership during healthcare emergencies that may benefit patients, experienced professionals and young trainees. The importance of communication, doctor-patient relationship, empathy and psychological sensitivity in the making of a physician – as fundamental factors for enhanced care humanization - are core issues of medical education. This is even more relevant at a time of increasing awareness of the importance of meeting the psychosocial needs of patients and their families. The COVID-19 pandemic surely had a deep impact on clinicians' lives, minds, and relationships as both health care professionals and human beings [27]. Unless its critical consequences on healthcare systems, this emergency may offer the space for identifying innovative solutions and find ways to maintain focus not only on the clinical aspects of the medical practice, but also on how to improve the humanization features of the care for patients and their families. Finally, this crisis has highlighted the professionals' human side and the importance for them to recognize their own human feelings, worries, and concerns. Health systems are warranted to recognize – starting from the medical education - that healthcare professionals are humans too by legitimizing their empathetic response; however, a practical plan to strengthen the healthcare providers psychological resilience

and work engagement during pandemic emergencies is needed to prevent them from becoming “second victims” in this scenario [27].

This study has limitations. Our purposive sampling was limited to Italian residents in child neuropsychiatry. While this may limit the transferability of findings to other contexts, it should be highlighted that residents were volunteering during the COVID-19 outbreak in ***blinded***, one of the most hit regions in the Italian territory. As such they represent a “critical case” sample. Additionally, we did not explore the psychological impact of volunteering on medical residents mental health. Future studies are warranted to assess the risk of burnout, post traumatic symptoms and moral distress in this population.

In summary, this paper reports on specific themes that characterized the experience of residents in child neuropsychiatry while volunteering in indirect care activities in Italian COVID-19-designated hospitals during the pandemic outbreak. The themes highlighted the specific actions in which residents were involved, as well as their emotional responses and the resources and rewards that they reported for their personal and professional growth. We know that this was not an isolated case and that similar volunteering experiences may have been in place in other countries [28,29].

Consistently, the timely availability of these findings to the international community may support with evidence the role that young residents in medical specialties may play during healthcare crisis in emergency care settings. Nonetheless, these results may also inform the accurate and strategic plans for the involvement and integration of volunteering residents in medical emergency teams during future epidemics.

Finally, young doctors in training and medical educators can help document and analyze the effects of the current changes to learn and apply new principles and practices to the future of medical education. Although the pandemic has posed a terrible toll on the

healthcare system³ and medical education programs [9], it can offer an opportunity to rebuild our existing approach to medical training. The COVID-19 pandemic is going to have the immediate and long-term effects on young doctors well-being, professional identity, and clinical experience. Nonetheless, this unprecedented crisis offers an opportunity to medical education leaders to provide relevant learning contents. Examples are the importance of psychological support for patients, families and care providers, the acquirement of more sophisticated communication and relational skills to better meet patients and caregivers needs and to manage difficult conversations, and the development of team working skills to enhance multi-disciplinary work. Perhaps, even more crucial, is the hidden curriculum that is provided to residents during this healthcare crisis [30]. By role-modeling the ability to cope with medical uncertainty and to make difficult decisions in high-anxiety clinical situations, this critical situation is providing precious lessons that are expected to shape young doctors leadership and management styles. Similarly, the interdisciplinary experiences that residents are doing when volunteering in COVID-19 hospitals are teaching them how to maintain solidarity and respect of different perspectives during a crisis. Finally, this situation is deeply highlighting the value of self-care for helping professions: this is expected to impact on the residents' attention to the relevance of burnout prevention in medical professionals.

In sum, the professionalization of young doctors should be considered a process developing across the continuum of education, training, and professional practice. In our perspective, and according to the study results, COVID-19 constitutes an invaluable opportunity for shaping a professional identity for what being a doctor is all about. Young doctors are currently developing their medical knowledge, deepening their professionalism, applying interpersonal communication skills, and contributing meaningfully to medical practice, even in challenging situations. These competencies - acquired "on the road" by child neuropsychiatry residents enrolled in this study - are

crucial and may serve as a model for broader specialty medical education during times of crisis.

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Table 1. Sample description.

Id	Age	Sex	Specialty year	Length of volunteering
				experience (days)
01	27	M	I	20
02	35	F	I	10
03	27	F	I	25
04	28	F	II	10
05	28	F	II	15
06	31	F	III	10
07	29	F	IV	10
08	30	F	IV	10

Table 2. Semi-structured interview guideline.

N.	Question
1	Can you describe the volunteering experience in COVID-19 designated hospitals in your own words?
1a	What feelings?
1b	What did it mean for you?
1c	What positive and negative aspects?
2	What is the difference between providing care due to the epidemic and working in your original clinical setting?
3	What challenges did you encounter?
3a	How did you respond?
3b	What external support did you receive?
3c	What other support did you need?
4	Sitting here now, what are your thoughts on this experience?
4a	Has your professional perspective changed since directly facing this experience?
4b	What lesson learned from this experience for your personal and professional growth?