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David Chaput looks at work stress and devises a battle plan

Battle Fatigue

Half of consultants and a quarter of general practitioners are planning early retirement. Changes in the health service, patient demands, stress and dissatisfaction with their roles are dominant reasons. Our profession, devoted to patient care and health promotion, does little to prevent stress damage amongst its own members. Until recently the same was true of the armed forces. The average ratio of battle fatigue cases to the wounded is one in three but this can be reduced to one in ten by awareness of risk factors, effective prophylaxis and early treatment.

What is the battle?

Most of us struggle with adversaries bearing names such as bureaucracy, work pressure, stress, ambition and selfishness. In reality these are only munitions; our enemy is the Prince of this world.[1] Many antipersonnel munitions are designed to maim rather than kill; the art of modern warfare is to stress enemy soldiers to the point when they lose their will to fight. A cynical and chronically wounded Christian is far more useful to our Enemy than one who has left the church completely. As in conventional warfare, combat stress is often the deciding factor between victory and defeat in our daily professional lives.

Causes

Cognitive
- Time pressure
- Too much or too little information for decision-making
- Too many or too few possible choices of action
- Professional and personal isolation
- Relational difficulties within our work units

Physical
- Sleep deprivation (post on-call)
- Chronic tiredness

Armed Forces' combat stress control manuals also mention immobility and enforced passive postures. Doctors frequently feel helpless to defend themselves and their profession against disgruntled individuals and media offensives.

Signs and symptoms

Elimination of certain levels of battle stress is neither possible nor desirable. Stress increases alertness and vigilance, strength and endurance. Sharing work stress gives a sense of the elite, increasing cohesion within our working unit and producing considerable personal sacrifice. As stress increases we experience symptoms of autonomic arousal but also experience tiredness, headaches, trembling, anxiety and irritability.[2] We become angry with our partners and other team members, losing confidence in the team or ourselves. We may feel anger, guilt or grief over previous personal failures. Moaning and complaining become more common.

Soft signs
- Apathy
- Arguing
- Constant suggestions
- Lack of personal hygiene
- Memory loss
- Rapid emotional shifts
- Reckless behaviour to self, patients and staff
- Sleep disturbance
- Social withdrawal

Hard signs
- Abusing alcohol or drugs
- Fighting with colleagues
- Failing to attend to patients
- Inappropriate sexual relationships
- Time off work for no apparent reason

Risk factors
- Food deprivation
- First time in combat
- Home front worries
- Insufficient information
- Insufficient tough/realistic training
- Intense battle with many wounded or killed
- Poor unit cohesion
- Sleep deprivation

Battle fatigue is not new; it is recorded in the first Israelite combat.[3] They had just become a nomadic people: like many doctors in training, daily living essentials were no longer guaranteed. Their unity was under stress from water and possible food deprivation.[4] They had had little training for their first battle. In the same way, despite improvements in medical education, house officers frequently complain that they were ill-prepared for the realities of daily medical practice. Thousands of years later, 1973 studies on Israeli soldiers during the Yom Kippur war showed that battle fatigue rather than bravery decoration were predictable. Similarly, poor performance amongst medical students is often related to personal problems.

Prophylaxis of Battle Fatigue

Realistic training. I recently spoke to a young house officer at a

mission field refresher course. She was about to undertake her first tour of duty in Sudan: she had no idea of local medical or social problems nor what equipment would be available. She only knew that she would be the only doctor and was understandably stressed. On a positive note, most UK medical schools are incorporating a shadow house officer period for final year students. Working alongside experienced house officers, students are given a realistic run-in to house jobs.

New personnel. Inexperienced personnel are especially at risk; however, even experts will under-perform in a new situation, particularly after a rapid transition. The consequent underperformance is humiliating and stressful. This is a factor in a lot of often unintentional teaching by humiliation. New arrivals should be welcomed by a senior team member and introduced to other team members. Ideally they should be allocated a 'buddy' for a few days. Many medical schools have a 'Mummies and Daddies' system when senior students look after Freshers, teaching them the tricks of the trade and giving support and encouragement. Newcomers should be given a chance to exercise their skills before being exposed to potentially stressful situations. Instead, many junior doctors arrive to find both registrar and consultant on holiday, numerous complex ward patients, a solo clinic waiting and A&E referrals stacking up!

Understand family structures. The successful functioning of doctors and students is critically dependent on the support of their families and loved ones. Maximise access to these supports especially during crises.

Social interaction. Encourage social activities outside working hours. Sharing food has an ancient bonding power and is particularly useful after times of stress. The risen Lord Jesus cooked everyone breakfast before recommissioning Simon Peter.[5]

Team persona. Capitalise on the positive elements of your team by telling stories about previous successes under difficult conditions. Most doctors like to hear stories about each other. Tell new entrants about some of their predecessors who enlivened the team's medical practice.

Leadership. Ideally, team members should always have the same leader, responsible for maintaining a sense of mission and cooperation. The cornerstone of prevention is the protective power of personal relationships between team members. Working alone for significant periods has never been good![6] A team leader should look out for his team's welfare; for example, the medical registrar on call could ensure that his or her team all get a meal break in the mess and even make a round of drinks in A&E. Team members should know that their colleagues are looking out for them and not competing with them.

Food and Rest. Leaders should ensure that their team is well fed, hydrated and adequately rested. Thankfully, protected sleep for UK house officers is in place. Food and fluid should be freely available during periods of duty; unhappily, in many hospital trusts this has come to mean an under-stocked and often malfunctioning vending machine.

Debrief. From the start of medical school, doctors share in human tragedy. I was quite unprepared for dissecting cadavers and witnessing deaths. Strangely, I didn't discuss my feelings with colleagues until recently. All too often, doctors end an unsuccessful resuscitation by rushing on to the next emergency, almost as if nothing had happened. Critical event debriefing is a central element of combating stress. Debriefing not only allows lessons to be learned but also allows participants to resolve any misunderstanding or feelings of mistrust. The macho culture pervading most medical institutions often lets doctors avoid examining their feelings and psychological issues. Sharing feelings about a common experience reduces the sense of isolation and guilt.[7]

Treating established battle fatigue

Treatment for armed service personnel is guided by the 4R principle.

Reassurance. Many doctors, especially men, imagine that their professional status should render them immune from life's stressors. Most doctors experiencing battle fatigue are experiencing a normal stress response and should be reassured. A lot of doctors imagine that everyone else is coping well. Following my own depressive illness, the 'loonies lunch club' was formed, only open to staff who had received psychiatric treatment. I believe it went some way to overcoming the stigma still attached to doctors with psychiatric problems. Certainly, it encouraged a number of students to contact us about their own difficulties.

Replenishment. Adequate hot food and non-alcoholic drink are as important in treatment as in prophylaxis. It is paradoxical that the more potentially stressful the medical working environment, the less available any adequate replenishment seems to be.

Rest. This is the most important factor for a lot of doctors. Following his fight with the prophets of Baal, God prescribed rest for Elijah's battle fatigue.[8] It is also Jesus' promise to people with exhausting jobs.[9]

Restoration. Battle fatigued doctors should be involved in tasks that restore his/her professional identity as soon as possible. Generally speaking doctors don't like being patients and need to have their sense of competency and involvement restored. Zechariah gives a fascinating account of Joshua, the high priest, being accused by his adversary.[10] Although the angel orders his filthy working clothes to be replaced, Zechariah himself shouts out in his vision, 'Put a clean turban on his head!' The turban was a sign of authority; it is significant that the Joshua's reinstatement was instigated by one of his colleagues. Without reinstatement we cannot continue the battle and our enemy has scored.

Conclusion

Battle fatigue, until recently an unavoidable cause of reduced fighting capacity, is itself being fought by new initiatives.[11,12] It is time for doctors to do the same.

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KEY POINTS

As Christian doctors we fight bureaucracy, work pressure, stress, ambition and selfishness, but our real enemy is the 'Prince of this world', who knows that our exhaustion is helpful to his cause. Stress increases alertness, vigilance, strength, endurance and cohesion, but if it overwhelms our coping mechanisms it can lead to discouragement and demotivation. Doctors can learn much from the experience of the military. Battle fatigue can be largely prevented through realistic training, extra support in starting a job, good leadership, effective debriefing, adequate food, rest and being made to feel part of the team. Those already fatigued need reassurance, replenishment, rest and relaxation. All these principles are biblically based.

References

1. Ephesians 6:12
2. Psalms 22, 38, 55, 88
3. Exodus17:8 -15
4. Exodus 17:1-3
5. John 21:1-19
6. Genesis 2:18
7. James 5:16
8. 1 Kings 19:1-9
9. Matthew 11:28-30
10. Zechariah 3:1-5
11. The Virtual Naval Hospital: Combat Stress Manual *http://www.vnh.org/combatstress*
12. 528th medical detatchment (combat stress control) *http://www.bragg.army.mil/528csc/default.htm*