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Castles in the air: civilian trainee experiences with the RAF

It is a little-known fact that specialist registrar training allows an elective period of up to 3 months without affecting a trainee's Certificate of Completion of Specialist Training (CCST). The Postgraduate Dean for Oxford had discussed the idea of such an elective scheme with the military and I therefore saw in the elective an opportunity to do something different before becoming a consultant. As an ex-member of the Territorial Army, my wife was very supportive and encouraged me by telling me that I would never withstand the rigours of a military lifestyle.

Initial suggestions that the military was sure it could 'do something with a psychiatrist' turned out to be more than true: I ended up with a choice of three positions, one of which was in Germany. However, organising the elective was not easy as this was a first for me, the military and my hospital management. The brunt of negotiations was borne by Defence Military Services and hospital management. My NHS consultant had been given almost a year's notice and was very supportive, but without a pre-existing framework for arranging such an endeavour, it was perhaps inevitable that there would be some people claiming that I had not spoken to them when I should have or not given enough notice. I also found that people tend to time the notice given not from when they are first informed, but from when forms are handed in. Detailed haggling over finances and uncertainty over dates created by deployments to the Gulf meant that final confirmation came a little close to the wire. When the time came to leave my NHS post, it was difficult not to feel a pang of guilt, not to mention trepidation at starting something so different.

My original choice of joining the Navy was scuppered by deployments to the Gulf, leaving me without a supervisor. Fortunately, it was possible to arrange an alternative attachment to RAF Brize Norton at short notice – ironic when one considers how long it had taken negotiations between the NHS and the Defence Military Service to set the elective up in the first place.

The Department of Community Psychiatry (DCP) at Brize Norton is one of the main psychiatric units in the RAF, however, as a result of deployments in the Gulf it was operating at below full strength when I arrived and I saw at first hand the anxiety created by the imminence and uncertainty of operational deployment (referred to as 'hurry up and wait'!). The reality of all this was brought home when our SHO was called up within a few days of my arrival. All military staff, despite their psychiatric jobs, had to wear uniforms. I was even called 'Sir' by the CPNs for the first few weeks, not something one gets a lot of in the NHS. Despite this, the DCP was similar to most other psychiatric teams: small, friendly and with as flat a hierarchy as military decorum would allow.

There are a few conditions that one might regard as the bread and butter of military psychiatry. There is expertise in post-traumatic stress disorder (PTSD), and I learnt to challenge my civilian preconceptions of PTSD as a chronic, difficult-to-treat condition. There are also syndromes such as Break-off, a dissociative condition associated with prolonged flight. It has been described as a strange sense of separation from the earth or even the feeling of a 'giant hand' moving the controls. It can be a precursor to other psychiatric disorders – including fear of flying, with obvious effects on a pilot's career. However, what was different about military psychiatry was not so much the nature of the conditions as the proportions they were seen in and the emphasis: each problem had to be seen from an occupational as well as a military viewpoint. The majority of what was seen tended to be in the middle range of problems normally seen by a psychiatrist: stress at work, relationship issues and mild-to-moderate depression. Other problems such as housing and unemployment were clearly going to be absent. Severe psychotic illnesses, for reasons that are less clear, tend to occur less frequently than in the general population: perhaps premorbid features prevent people applying. As for personality disorders, from my experience I would guess that many younger people at risk of personality disorder are diverted by the disciplined but positive environment of the military.

Each person was assessed in the knowledge that he or she might be deployed to a conflict zone at any time, or be carrying a gun on guard duty when you came in to work the next day. For these reasons, even comparatively mild problems required decisive action: a normal bereavement reaction might be enough to affect the medical status of an otherwise healthy individual. (There are several levels of such 'medical protection', each carrying a recommendation on a range of issues from guard duty to posting.) For someone with an interest in the philosophy of mental health, it was interesting to see how the values of the workplace affected the perception and management of mental disorder. In each case, the administrative issues had to be sifted from the medical ones. If someone expressed anxiety about deployment, would this be classed as an illness? These are difficult dilemmas for any compassionate doctor, but one has to remember that it is not a conscript army: recruits know the risks of working in the military and many remain fiercely loyal to the lifestyle.

If you thought social psychiatry was confined to asylums and assertive outreach, you would be wrong. The military had pioneered the concept of community mental health by taking psychiatry out of the office and into the barracks and work environment, sometimes encountering a degree of scepticism from the military's macho culture. However, community services had suffered as a result of cutbacks in the defence budget and work is now almost entirely out-patient based, despite a strong educational component (including regular courses on stress and flying phobia). It is hoped that the community focus will return

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in the near future, with much of the impetus being provided by the DCP's own commanding officer. His background in anthropology meant that there was much to discuss on the social psychiatry of military life. I wonder what a social psychiatrist would make of the low rate of schizophrenia in the military?

From a civilian's point of view, life in the military operated as a contract, albeit one of high stakes. The military gives a lot to its personnel, but expects a lot in return. In Brize Norton alone, staff can take advantage of everything from family holidays advertised in our waiting room to a hotel and hire cars for squaddies returning on leave from overseas. In return, though, the RAF will expect most personnel to change jobs and location every few years, and that is just in peacetime. Surprisingly, deployment was rarely at issue: many military personnel, if they do not regard it as the culmination of their training, at least accept it with dignified resignation. Usually the problem was simply one unwelcome posting too many or a personality clash at work, made worse by a widespread mistrust of the military bureaucracy. Sometimes the implicit bargain between the military and the individual would work against us: a patient might be upset because a service such as counselling was not immediately available via the RAF, although in the NHS it is not unusual for patients to arrange this themselves. Rarely, someone would seek to end this implicit deal with the RAF and leave early, no easy matter, as breaking one's contract with the RAF is a considerably more serious matter than breaking a civilian work contract. For this reason, a medical solution might be sought for any impasse, coming back to the quasi-philosophical issue of what constitutes a mental disorder.

Being a civilian had the advantage that despite my friends' concerns, I was never in any danger of being posted to any 'hotspots' (although I understand that it is possible to spend some time in a 'lukewarm' location if one should wish it). One drawback was that in a close-knit rule-bound community such as the RAF, some patients perceived me as unable to understand the rigours of the military lifestyle; although I am not sure if that is entirely fair to say this of anyone who has survived pre-registration jobs. There are definitely some perks, though. I can think of no NHS job that would allow a trainee to fly a £16 million flight simulator.

I have been a willing guinea pig in a scheme to encourage specialist registrars to sample medicine in a military environment. I hope this scheme will flourish – it has been a very interesting time for me and I am maintaining my links with the Department of Community Psychiatry at Brize Norton. For those interested, from psychiatry or any specialty, it should be possible to arrange an elective or special interest session. Give plenty of notice for the elective and get approval from your postgraduate dean, your consultant and management. However, there is nothing to stop you making contact with the military to organise special interest sessions: from my experience they will be only too happy to talk to trainees.

Declaration of interest

None.

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