

Short timers syndrome among medical trainees: Beyond burnout

S. P. Stawicki, MD¹

¹ Principal Scientist, OPUS 12 Foundation, King of Prussia, PA, USA

ABSTRACT

The short timers syndrome (STS) was first described and studied in the military. Although not a new phenomenon, it was more formally recognized in the 20th century during the two World Wars. The STS has been well documented during all major military conflicts and deployments since then. In a way, STS can be viewed as an extreme form of burnout. As such, STS can be observed among medical trainees who are on busy clinical services for prolonged periods of time. In addition to its negative effects on the healthcare team, burnout and STS have the potential to adversely affect patient care. It is important to be aware of signs and symptoms associated with medical trainee burnout and STS because early recognition of these signs may allow prompt intervention and prevent further progression of burnout.

Cite as: Stawicki SP. OPUS 12 Scientist 2008;2(1):30-32.

Correspondence to: S. P. Stawicki, MD. OPUS 12 Foundation, 304 Monroe Blvd, King of Prussia, PA, 19406 USA.

Keywords: Medical training, Short timers syndrome, Burnout, Prevention strategies, Identification strategies.

The *short timers syndrome (STS)* was first described and studied in the military.¹⁻² Although known since the antiquity, it was more formally recognized in the 20th century during the two World Wars. The *STS* has been well documented during all major military conflicts and deployments since then.

Associated with longer tours of duty, the *STS* is defined as a drop in morale, rise in anxiety, and a withdrawal from commitment to combat. In many cases, soldiers lost so much combat effectiveness that they had to be moved to noncombatant positions as the end of their tour approached.³ The behavioral patterns noted among *short timers* in the military could be dramatic. In 1967, Dowling provided the ‘classic’ description of how *STS* evolves:²

“There is the period of anxious apprehension, a potentially severe syndrome of emotional distress beginning mildly two to three months before rotation, but usually occurring obviously in the last three weeks of the tour and most marked the last three days prior to rotation. Irritability seems to alternate with euphoria. Pacing is a common sign. Quiet hard working individuals who for eleven and three quarters months have put up with deprivations, long working hours, and continually increased demands will suddenly behave in a rather inappropriate manner.”

After all, few men wished to be the last to be killed or wounded as the war or the deployment approached its final days.⁴ The *short timers syndrome* was at times noted as much as two to three months before the soldier’s expected date of return back home, as he or she counted down the remaining days of deployment.⁴ In a way, *STS* can be thought of as an extreme form of *burnout*.

At times, one can observe *STS*-like behavior occurring among house officers rotating on busy clinical services. Behavioral patterns observed in house staff with *STS* appear to represent a spectrum, with the traditional *burnout* at one end and the ‘disabled-like’ state of *STS* on the other end. Most of us are well familiar with the phenomenon of *burnout* among medical professionals, which has been defined as a subtle process in which a medical practitioner is gradually caught in a state of depersonalization, mental fatigue, feeling *completely empty and drained of energy*.⁵ Multiple reasons for *burnout* have been proposed, including long working hours, chronic sleep deprivation, negative relationship(s) with peers, inability to forgive oneself and others, lack of professional growth, and difficulty adapting to adversities.⁵⁻⁷

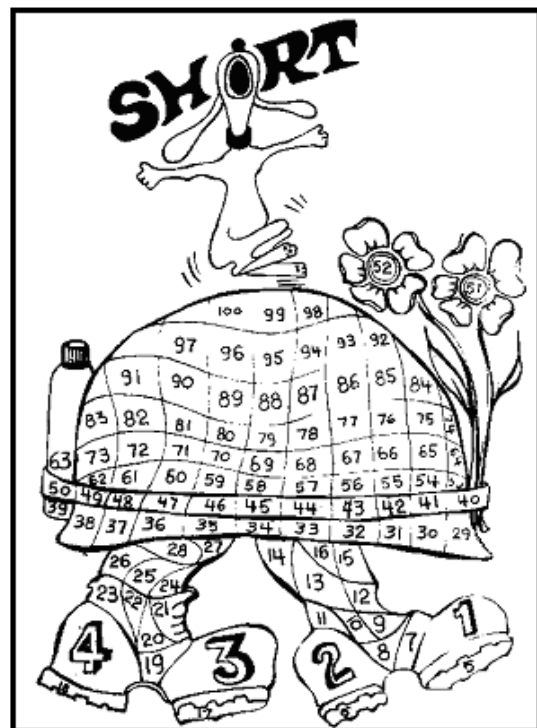


Figure 1. Cartoon showing a soldier’s 100-day countdown before coming back home. It is not uncommon among medical trainees to count days till the end of the rotation and/or the training program.

Here is a theoretical scenario of how *STS* may evolve among house staff. Anxious and insecure at the beginning of the residency, the house officer tries to impress his or her superiors and slowly gains confidence and required skills as the training rather quickly advances past the mid-point. After completing approximately three-fourths of the required training, although this is not universal and varies from individual to individual, house staff may gradually show signs of *burnout*. These signs may take

a form of obvious lack of interest, ambivalence, lack of proactive behavior, avoidance of responsibility, lack of attention to detail, and tendency towards reduced availability to perform even simple tasks (i.e., ‘disappearing’). At times, this pattern may manifest first as a decline in academic performance (i.e., a ‘stellar’ resident who unexpectedly fails the in-service examination).

Some house officers may manifest a mild form of *STS*, characterized by selectively choosing to perform ‘easy’ tasks, or only tasks of personal interest to them. For example, a mid-level surgical resident completes only two interesting consultations out of the total seven assigned and performs none of the postoperative checks, even though he or she was not in the operating room and received only eight easy triage calls during the entire night. The most severe forms of house officer *STS*, or ‘disappearing’ and ‘insubordination’, consists of the house officer simply not responding to calls or pages, behaving abusively toward their peers, and refusing to perform even simple tasks or fulfill minimal requirements during their clinical rotations. In these severe cases, a disabled-like state virtually ‘removes’ the house officer from their respective team, much like the *STS* effectively ‘removes’ the soldier from the battlefield. While quite disabling to the individual experiencing this extreme form of *burnout*, the effect of *STS*-associated behavior can be very disruptive to the entire healthcare team and can potentially jeopardize patient care. In addition, *burnout* can significantly affect other parts of a medical practitioners’ life – including their home and family.⁵

How can we address or try to prevent the *STS*-like behavior among house staff? Can active education regarding this phenomenon help prevent it, or would it simply legitimize this behavioral pattern? As previously mentioned, numerous causes of *burnout* among healthcare professionals have been identified.^{5, 7} Perhaps trying to identify and address these potential causes as well as providing environment that fosters honest and quality feedback between the house staff and their superiors could be a good start. This may take a form of a ‘bonding day’ or a ‘town hall meeting’, where issues are identified and appropriate solutions proposed. And let’s not forget that positive reinforcement works a lot better than oppressive ‘beating down’. In addition, there are resident wellness programs, which have been shown to help residents cope with stress and traumatic events, and could be helpful in *STS*-like situations.⁸

It has been proposed that in order to ‘escape’ from the *burnout* state, the affected individual needs to change his or her perceptions of the work environment.⁵ One way to start is to foster mentorship within the training program – a healthy relationship with senior members of the team and recognition of their accomplishments appear to be effective in preventing *burnout*.^{5, 9} This may then be followed by trying to eliminate overly harsh, ‘unhealthy’ self-criticism, which is known to decrease self-esteem; planning for continued professional growth and development; and enriching the resident’s personal life away from hospital or medical office.^{5, 10} It is also important to learn to look at adversities as tests that must be ‘passed’ on the path to accomplishment, which includes accepting and adapting to these adversities.¹¹ It has been suggested that the difference between high achievers and underachievers is that high achievers use adversity and struggles to fuel personal and professional growth, and underachievers allow difficulty and adversity to overwhelm and discourage them.¹² It may also be helpful to educate the house staff about having reasonable expectations, especially when it comes to seniority within the residency. Specifically, it is important for house staff to realize that as they advance in rank, although their roles change, the amount of work tends to remain the same – a potential factor leading to disappointment.¹³ Also, it is crucial to remember that medical trainees are very likely to suffer from depression, and that both *burnout* and depression can contribute to suboptimal patient care and increase in medical errors, respectively (Figure 2).¹⁴⁻¹⁵ It is not clearly known what is the overlap between *burnout*, *STS*, and depression among medical trainees, but there seems to be at least some association.¹⁴⁻¹⁵

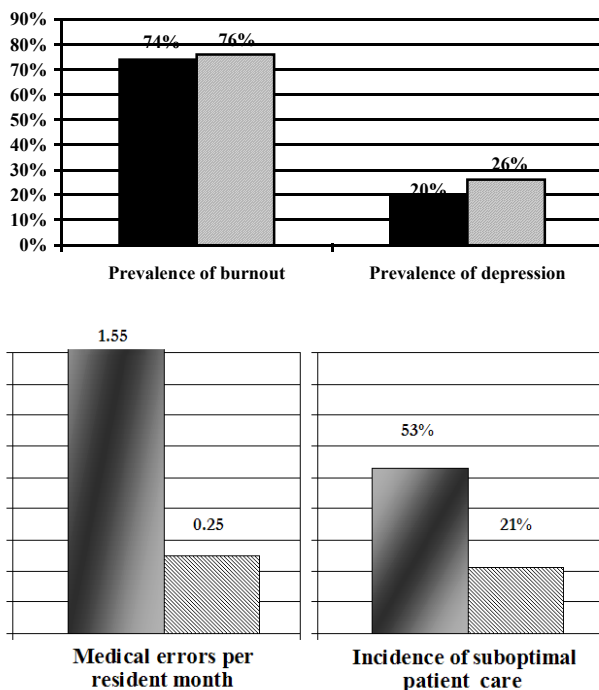


Figure 2. Prevalence of *burnout* and depression [top part of figure] among medical trainees in two major studies.^{14, 15} Number of medical errors per resident month among medical trainees with depression (1.55) and those without (0.25) [left lower figure]. Incidence of episodes of suboptimal patient care among medical trainees with *burnout* (53%) and without *burnout* (21%) [right lower figure].^{14, 15}

SUMMARY

Many questions regarding *burnout* and *STS*-like behavior among medical and surgical residents remain to be answered, but the ability to identify and address *burnout* and *STS* among house staff may result in improved resident satisfaction, better patient care, as well as better communication and overall lower levels of conflict among healthcare team members. Perhaps educating healthcare professionals and trainees about the phenomena of *burnout* and *STS* as well as encouraging open discussion of these problems could be the best first step to the solution. Given the fact that *STS*-like phenomena among medical trainees are poorly understood, further research is warranted into the etiology, identification, and remediation of this serious problem.

REFERENCES

- [1] Dedic G, Krstic J. The personality of soldiers with inappropriate behavior patterns at the end of military service. *Vojnosanit Pregl* 1997;54:11-17.
- [2] Dowling JJ. Psychological aspects of the year in Vietnam. *USARV Med Bull* 1967;2:45-48.
- [3] Moskos CC Jr. The American combat soldier in Vietnam. *J Social Issues* 1975;31:31.
- [4] Towell P. Forging the sword: unit-manning in the US Army. Center for Strategic and Budgetary Assessments Report. 2004. Washington, DC.
- [5] Espeland KE. Overcoming burnout: how to revitalize your career. *The Journal Contin Educ Nurs* 2006;37:178-184.
- [6] Martini S, Arfken CL, Balon R. Comparison of burnout among medical residents before and after the implementation of work hour limits. *Acad Psychiatry* 2006;30:352-355.
- [7] Papp KK, Stoller EP, Sage P, Aikens JE, Owens J, Avidan A, Phillips B, Rosen R, Strohl KP. The effects of sleep loss and fatigue on resident-physicians: a multi-institutional, mixed-method study. *Acad Med* 2004;79:394-406.
- [8] Dabrow S, Russell S, Ackley K, Anderson E, Fabri PJ. Combating the stress of residency: one school's approach. *Acad Med* 2006;81:436-439.
- [9] Weger NS. My mentors. *Curr Surg* 2006;63:66-67.
- [10] Ruiz, MA. The four agreements: a practical guide to personal freedom. 1997. San Rafael, CA: Amber-Allen Publishing, Inc.
- [11] Tracy B. Goals: how to get everything you want faster than you ever thought possible. 2003. San Francisco, CA: Berrett-Koehler Publishers.
- [12] Tracy B. Change your thinking, change your life: how to unlock your full potential for success and achievement. 2003. Hoboken, NJ: John Wiley & Sons.
- [13] Stawicki SP. Changes I experienced as a resident. *Curr Surg* 2004;61:98-99.
- [14] Fahrenkopf AM, Sectish TC, Barger LK, Sharek PJ, Lewin D, Chiang VW, Edwards S, Wiedermann BL, Landrigan CP. Rates of medication errors among depressed and burned out residents: a prospective cohort study. *BMJ* (2008), doi:10.1136/bmj.39469.763218.BE.
- [15] Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136:358-67.

Permission to make digital or hard copies of all or part of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for profit and that copies bear this notice and the full citation on the first page. To copy otherwise, or republish, to post on servers or to redistribute to lists, requires prior permission and/or a \$5.00 fee.

OPUS 12 Scientist – A Quarterly Publication of OPUS 12 Foundation.
© 2007-2008 – OPUS 12 Foundation, Inc., King of Prussia, PA 19406 USA.