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NASSER SHURIQUIE

Military psychiatry – a Jordanian experience

Jordan is a Middle-Eastern country, located North West of Saudia Arabia. The total area is 93 300 sq km. Jordan has borders with Iraq, Israel, Saudi Arabia, Syria and the West Bank. Regarding ethnic groups, about 98% of population are Arabs, 1% Circassian and 1% Armenian. Moslems make up around 94% of the population and the remaining 6% are Christians. Jordan is a constitutional Monarchy that became independent from British administration in 1946. The population of Jordan is 5 307 740 (July 2002 estimate), the capital is Amman and the language is Arabic.

The Jordan Armed Forces include Royal Jordanian land forces, Air Forces, Naval Forces and special operation forces. The size of the Jordan Armed Forces is around 100 000 professional military personnel.

Evolution of the Royal Jordanian Medical Services

The Jordanian military medical services started in 1941 with one physician, limited equipment and some medicines. In December 1948, a Lebanese physician was appointed as the first director of the Royal Jordanian Medical Services (RJMS). That same year, the first front-line field dressing station was set up for the Jordanian Army in Beitunia near Ramallah (west bank of river Jordan). After the Arab–Israel war in 1948, officials recognised the importance of establishing a hospital to serve the country's military and some barracks of the Trans Jordan Frontier Forces were set up for this purpose. These barracks formed the nucleus of the main Military Hospital in Marka, Amman that went on to provide medical care not only for soldiers, but also for their dependants. Following the recognition of the imperative need for these medical services, the King Hussein Medical Centre was founded on August 14 1973. This centre went on to become an 816-bed comprehensive and modern medical complex. The King Hussein Medical Centre is currently one of the main referral and educational centres in Jordan.

Roles of the RJMS

The main task of the RJMS is preserving the health of the officers and soldiers of the Jordan Armed Forces, police, intelligence department and civil defence through providing field medical services as well as hospital services. Other tasks include: offering comprehensive medical insurance to more than a third of the population, and treatment of costly complicated medical and surgical cases referred from the Ministry of Health, the Jordan University Hospital and the private sector. Military hospitals provide medical services to all the citizens and residents of some deprived provinces, and play a regional role by treating patients referred from Arab countries.

RJMS has participated in international peacekeeping forces, and provided military field hospitals and personnel to United Nations peacekeeping missions. The Military Health Insurance (MHI) system of the RJMS has expanded to-date to cover about 1 840 000 people (35% the Jordanian population), of whom less than 10% are active military and police personnel.

Psychiatric services in the RJMS

Psychiatric services started in the early 1960s with a small number of physicians, whose main role was to assess the military personnel's fitness to serve in the army. These doctors were sent to the UK and sponsored to have training in psychiatry and to obtain qualifications. A psychiatric unit was established in the mid-1960s in the Marka Military Hospital, Amman. It consisted of 20 beds for males and 10 beds for females. A psychiatric training programme for residents was introduced soon afterwards to enable doctors to receive training in psychiatry before they were sent to the UK.

Organisation of psychiatric services in the RJMS

The department of psychological medicine is a branch of the department of medicine. The head of the psychiatric department, who is currently Lieutenant Colonel, reports to the head of the medical department (Brigadier General). The psychiatric unit is currently based in the Princess Aysha Medical Complex, which was the original site of the Marka Military Hospital. The new complex is a comprehensive out-patient medical centre that provides medical cover to the psychiatric unit. The psychiatric unit

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was transferred to King Hussein Medical Centre in 1976, and became a department closely linked with the other medical departments. The unit was transferred back to Marka in 1997, which unfortunately caused its isolation from other medical departments. This misguided decision was taken by the hospital administration because of the low bed-occupancy rate. The issue of the psychiatric unit moving again to become attached to a general hospital remains an ongoing debate.

The current psychiatric unit has 12 qualified specialists in psychiatry who hold the Jordanian Board of Psychiatry, the highest qualification in Jordan. Two of these specialists are also members of the Royal College of Psychiatrists, and two others have a diploma in forensic psychiatry and a diploma in child psychiatry from the UK. Also at the unit, there are three clinical psychologists, a social worker and a trained group of psychiatric nurses. The current unit has 21 beds for males, with about a 98% occupancy rate, and 10 beds for females with about an 80% occupancy rate.

Psychiatric duties in the RJMS

The psychiatrists' work is divided between caring for in-patients in the psychiatric unit and doing the liaison work at seven military general hospitals that are located throughout Jordan. In these central and peripheral hospitals, psychiatrists hold out-patient clinics two to three times per week, in addition to carrying out psychiatric consultations for in-patients on medical wards. Psychiatrists treat a wide variety of patients belonging to different sub-specialities such as general adult, child psychiatry, old age psychiatry, etc. Psychiatric services are provided to military personnel, their dependants (civilian) and patients referred from other sources, such as the Ministry of Health. The standard policy of admission to the psychiatric in-patient unit is basically a short-term admission with an average 4–6 week stay. Military patients are discharged as soon as they recover. They then go through a period of rehabilitation before they are allowed to return to their units.

Furthermore, psychiatrists make recommendations to the medical board regarding soldiers' fitness to return to regular duties. They might recommend transfer to administrative work, discharge or early retirement.

Psychiatrists also participate in the selection of military officers, non-commissioned officers and soldiers jointly with the psychologists. Specific intelligence and personality tests have been developed and used for this purpose.

The International Peacekeeping Forces' experience

Jordan has been participating in the International Peacekeeping Forces since the early 1990s. Jordanian battalions supported by medical units served under United Nations (UN) commands in many countries, such as Croatia, Kosovo and East Timor. Jordanian military psychiatrists have been involved with the military field hospitals in a number of UN Peacekeeping missions, for instance in Sierra Leone, Eritrea and other troubled parts of the world. Their duties were mainly to ensure and maintain the mental health of peacekeeping forces as well as providing care for local populations. Having witnessed horrible scenes like mutilated bodies and been confronted with life-threatening events, a number of soldiers were repatriated by the military psychiatrists. Many developed features of post-traumatic stress disorder (PTSD) that required treatment. The majority made significant progress after repatriation and treatment. They returned to their units, but many have been exempted from armed duties.

The Jordanian Field Hospital at Mazar-i-Sharif in Afghanistan

Jordan has contributed to international alliance in Afghanistan and established a well-equipped military field hospital at Mazar-i-Sharif that consists of almost all specialities, including psychiatry. The main purpose of the hospital is to serve the local population.

Our psychiatrists' experience in Mazar-i-Sharif was unique and rich despite the mounting logistic difficulties, harsh weather and the language barrier. During the period from December 2001 to May 2002, the psychiatric team saw 940 patients from the local population who presented to the out-patient clinics. About 66.27% (623 patients) were diagnosed with anxiety disorder, depression, etc. The number of patients with psychosis was 96 (10.2%) and the number of patients with PTSD was 41 (4.36%). The team has observed severe psychosocial stressors including poverty, overcrowding and unemployment. The rate of attempted suicide presenting to the hospital is strikingly low – only one patient presented after taking an overdose.

Research and training

Research is encouraged in the RJMS. In fact, the promotion of psychiatrists is partially based on conducting published research. Several studies have been undertaken on the prevalence of psychiatric disorders in the army. The RJMS psychiatric unit is an approved training centre by the Jordan Medical Board in Psychiatry. This board gives doctors who pass board examinations a certificate of speciality in psychiatry. At the unit, there are a number of trainees who are enrolled in this psychiatric training scheme.

Challenges and hopes

The primary issue with psychiatry in the RJMS is the pace of its development. It is falling behind developments in other fields such as surgery, cardiology and ophthalmology. Unfortunately, these fields appear to be much more appealing and prestigious than psychiatry. The administration that decides the needs of psychiatry does not include psychiatrists, therefore it is difficult for them

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to understand the genuine needs of psychiatry such as improving the training of the multi-disciplinary team, allocating more resources and improving the immediate environment of patients. Psychiatrists do not seem to be able to promote psychiatry and to be influential in decision-making.

Conclusion

Military psychiatry in Jordan provides an interesting experience of treating both military personnel and civilians. Military psychiatrists have had a leading role in establishing psychiatric services in Jordan and have supplied the psychiatric society with excellent ex-military psychiatrists, who work in the private sector and in universities. Military psychiatry provides services to about a third of the Jordanian population, serves the military and participates in UN peace-keeping forces; a job that produces intense feelings of satisfaction and pride.

Nasser Shuriquie Specialist in Psychiatry, the Royal Jordanian Medical Services, PO Box 143516, Amman 11844, Jordan. E-mail: nasser_shuriquie@yahoo.com

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PETER HARDWICK

Formarrhoea

The epidemic of formarrhoea blighting adult mental health services is spreading to child and adolescent mental health. Threatening to arrive all about the same time are forms to do with risk assessment, care programme approach, outcome and activity recording, Commission for Health Improvement, child protection, assessment of trainees . . . and more. They will likely cause an avalanche when added to the mountain of existing forms and Government circulars already piled up on my desk. Forms are increasingly governing all aspects of clinical practice. They threaten to get in the way of doing the job.

I admit an aversion to bureaucracy that makes me resent being required to fill in or tick boxes on more forms. They bring certain images and phrases to mind. I find myself grumbling 'Stalin, Third Reich, Kafka, Asperger, or just trust me to do it right', whereas I know I should think 'safe practice, avoiding enquiries, information systems, research . . .' Perhaps it is due to unresolved adolescent rebellion (I was brought up in the 60s). However, I have found that my resentment is shared by younger colleagues who, when faced with yet another column of boxes to tick, actually shout out rather more obviously unpleasant things. Here is a new variety of 'tic disorder'.

My fear is that the heart of good clinical practice, the clinician–client relationship, will be so controlled by forms and procedures that there will be little time or energy left to develop rapport. Instead of concentrating on joining the client where they are in their world in order to develop understanding, the clinician will be preoccupied by how to fill in the latest risk assessment form. The standard of good practice will be a set of correctly-completed forms and followed procedures. Never mind how you and your patient actually get on. It reminds me of an episode from Richard Gordon's *Doctor at Large*. Dr Potter-Phipps, a society doctor practising privately in Harley Street, had acquired a newly-invented electrocardiogram (ECG) machine that he used to impress his patients and he took it with him everywhere. The early large ECG machine was driven in a second Rolls Royce that followed behind Dr Potter-Phipps' own Rolls on home visits. One day, he returned from a man who had suffered a stroke looking worried. 'A near thing, dear boy' he reported to his assistant as he came through the door shaking his head, 'a damn near thing'. 'What, did you pull him through?', asked his assistant. 'Oh no, the old boy's dead. But I only got the ECG there in the nick of time'. Likewise, our patients may not get better or even die, but never mind, as long as all the paperwork is done they will succumb in good form. And I know what formarrhoea feels like from the patient end, having been hospitalised for depression. What seemed to matter most to in-patient staff was monitoring my psychiatric state, whereas I would have welcomed more understanding and input from the underlying emotional crisis I was going through.

Associated with form filling is the irritation of rubber stamping. As consultants, we are increasingly being asked to sanction, in writing, innocuous activities where previously a nod and a wink would have sufficed. Again, images of a police state and being expected to function as a bureaucrat rather than as a clinician. Recently, when faced with a particularly silly request for rubber stamping, I must confess a sneaky delight in having signed myself 'Obergruppenführer'.

Two forces seem to be accelerating formarrhoea and all that is associated with it. First is the pressure to create risk-free public services, together with the belief that forms are the way to do it, emanating from the culture of litigation and compensation. The huge sums awarded when things go wrong, and the search for scapegoats in inquiries, creates the atmosphere of fear, pushing us to defensive practice. The overriding principle is to be seen to be doing the right thing. As long as correct procedures are followed, forget what really goes on at the coalface. It is the bad press and financial consequences of high-profile mistakes or plain bad practice of a tiny minority of our colleagues that is intruding into the good practice of the rest of us. Lest we think we are being singled out in

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