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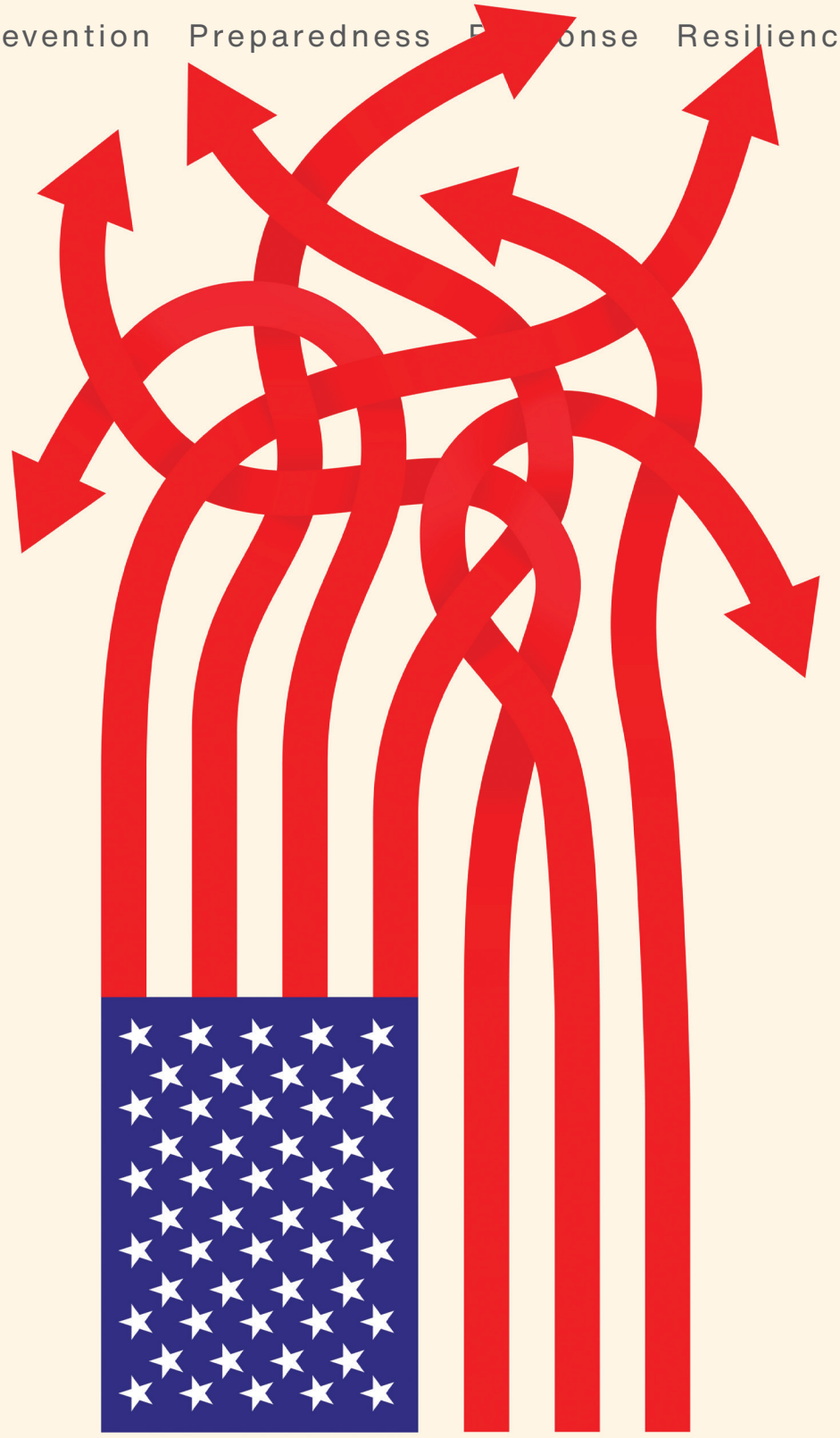

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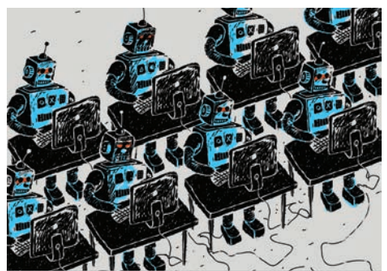

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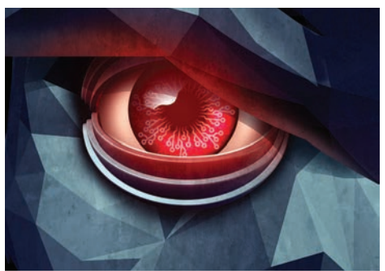

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comment

At the EENA 112 conference in Latvia this November, Patrick Lagadec took a satirical approach in his keynote presentation. The *CRJ* Advisory Panel Member discussed the Covid-19 pandemic from the perspective of the virus itself, drawing parallels with other crises. He analysed the virus's strategy in which its 'special forces unit' repeatedly expressed gleeful amazement at how humanity is facilitating Covid-19's deadly mission at every step.

Why do we so often make it easy for disasters to take hold and cause such tragic tolls? One reason, posits Gill Kernick on p68, is that: "Many of our top-down, bureaucratic and mechanistic ways of thinking, grounded in mythical cause and effect narratives... are becoming redundant."

Feedback in the session I moderated at the European Forum for Disaster Risk Reduction has also stuck with me. One participant noted: "We need to know our citizens better." Another highlighted the continued weakness in approaching disaster at a cross-sectoral level.

This is the very *raison d'être* of the *CRJ* – to encourage knowledge sharing and action between disciplines; the articles on p38 and 62 exemplify good practice in applying transfer of expertise.

And on p74, Stefan Flothmann discusses how to change the mindsets of disaster-afflicted communities to ensure better recovery and resilience. The psychosocial phases he discusses are equally evident in nations, businesses, emergency responders and individuals; in other words, across most of humanity. Today, many seem to be gripped by the 'disillusionment' phase, ground down by the painful, drawn-out pandemic crisis.

This theme continues in Jennifer Hesterman's guest-edited focus on the USA (p78), an unflinching snapshot of issues in fire and rescue services, police and emergency management. A recurring concern – among other issues – is the public loss of trust.

We must rectify this. Solutions are there, but political posturing, geopolitical jostling, opportunism, protectionism and empire building are endemic. If we don't change, we are all simply facilitators: collaborators with, and enablers of our common enemy – disaster.

Staff endurance as a strategic resource

At the EENA 2021 conference in Latvia, **Magdalena R Lind** outlined her team's work on 'Stridsvärde' – a concept and tool to maintain the functional fitness of healthcare personnel in a crisis. Here, she provides more detail about how they worked with staff from a Covid-19 intensive care unit in Sweden by applying tried and tested military techniques

The Covid-19 pandemic has put a spotlight on the situation of healthcare professionals during a crisis. This article addresses challenges and lessons learned from the pandemic in a Swedish context where one ICU went against the tide. As an early mover, Södertälje hospital decided to invite resources and insights from other fields. This resulted in a mission statement and the creation of a toolbox dedicated to retaining staff by considering both their physical and mental fitness. What seems obvious to all of those involved in this initiative nevertheless remains a rare example of practical implementation and follow-up of strategies and interventions to address the situation of healthcare professionals in a systematic manner.

At the onset of Covid-19, the Swedish strategy for managing the pandemic was directly hinged upon the impact and strain on its healthcare systems. Restrictions and appealing to the Swedish people to keep their distance and to persevere were justified by the statement that: "Our healthcare is on its knees."

Staff endurance

Equipment and medicines can be kept in emergency stocks or scaled up relatively quickly, but there is no equivalent for the qualified intensive care personnel who are needed to staff the beds. If we did not know this before, we certainly know it now. Staff endurance is a vital strategic resource to cope with a long-term strain.

If we do not study and understand how the ability of personnel to deliver care is affected by stressors, we cannot design interventions to address them effectively. Given that the capacity of our healthcare system has such a bottleneck, it is remarkable that we lack shared understanding of – and interest in – what causes the burden, impairs the functionality and how it can be addressed.

Based on our experience in crisis resolution and research conducted by our partner Niclas Wisén, a PhD student in stress and performance under pressure at Karolinkska Institutet, current accessible staff care seems to be based on 'more of the same' – such as counselling, managerial support and advice – as in everyday life. Some interventions could even be considered harmful, such as failing to understand that a person's strong reactions are adequate and appropriate, given the situation they are experiencing. The sources of stress, specific activities and situations have not been mapped and the measures that have been implemented have rarely been followed up.

At the March 2021 annual meeting of the Swedish Association for Anaesthesia and Intensive Care (SFAI), it emerged, for example, that among more than 50 participants, only Södertälje Hospital answered in the affirmative to the question of whether it worked systematically with staff on endurance and preventive measures.

Could one explanation be that we did not make the switch from working hard during an extraordinary, but limited, event to dealing with a prolonged period of stress? In cases involving mass casualties, such as a large traffic incident, the usual approach would be to push through (and maybe then collapse). Healthcare workers are trained to ignore their own needs.

The pandemic, however, did not present us with a visible point or end within reach to which recovery could be postponed. We had absolutely no margins for absenteeism, be it for sick leave or high personnel turnover. Waiting for the symptoms of burnout to begin could not be justified, neither from a resource perspective, nor in an ethical sense. Waiting for the manifestation of stress or

Photographer Staffan Löwstedt was invited into Södertälje hospital; his poignant photo series was featured in the Swedish Newspaper Svenska Dagbladet

Löwstedt photographed staff wearing PPE and holding photos of themselves in civilian clothes, showing the stressful conditions of working in a Covid-19 ICU

burnout and then activating the usual package of measures is of little help in such circumstances. Staff retention was crucial. We made it our mission to address this.

'Stridsvärde' is the word upon which we hinged the whole concept. This unique Swedish term describes the individual or group's physical and mental ability to function, to perform one's duties. It resonates with us because the word is a composite of 'strid' – meaning to fight, battle or exert effort – and 'värde', which means value or gradient.

We realised that we could tap into battle-proven experience and tools for endurance and performance under pressure or in chaotic conditions. These already exist within the armed forces; awareness of stridsvärde is built in when conducting defence exercises involving the military and civilians. There is a field of academic research to tap into and there is existing knowhow for adapting these tools to specific situations and contexts. Stemming from the military, the principles and instructions have already been made simple to teach and to be understandable – in other words, they can be termed 'squaddie-proof'. Unfortunately, during the pandemic, it seemed we forgot to use these hard-earned lessons on maintaining functional capacity (stridsvärde) in times of uncertainty and prolonged stress.

Functional capacity

Viewed from the front line, in this case the Covid-IVA (intensive care unit) in Södertälje, it is obvious that the staff's stridsvärde is crucial in assessing the pandemic's impact on healthcare. Yet the extent to which staff perseverance in itself is an element impacting the status of our healthcare services receives little attention. It rarely, if ever, appears in media reporting or decision-making guidance. Instead, the target is locked on the volumes of patient care, as became evident a year later, when summaries were made of lessons learned from the effects and management of the pandemic during the period from spring 2020 until early autumn.

At Södertälje Covid-IVA however, we took the opportunity to rediscover the application of the concept of stridsvärde during the spring and winter of 2020. In a civilian context such as health care, it was not a given that the military concept would gain a foothold, but it did. The almost self-explanatory concept allowed healthcare personnel to recognise that they were facing something new. It also provided opportunities to identify and work with an active approach to stress.

We have seen evidence of how society has made great sacrifices to deal with the pandemic. Now our resilience is being tested, as is our systems' ability to absorb disturbances while simultaneously maintaining basic functions. How do we then ensure that our systems and preparedness include the functional fitness – mental and physical – of personnel?

During long marches, soldiers are taught and, if needed, ordered to rest, drink and remove their shoes and socks during a short break every hour. This is the concept of 'Marschvila' – resting while marching; walking 50 minutes and resting 10 minutes every hour, whether they want to or not. ICU staff and management were instructed that scheduling and taking breaks were compulsory and not optional, in order to maintain stridsvärde.

Tactical reflection was also introduced – ICU staff and management were taught to conduct a short team huddle after a particularly strenuous event or when stress levels were high. Using the basic principles of an after-action review, tactical reflections – ie huddles – were used to reflect on what had gone well, what could be done even better and how everyone was feeling. This is a battle-proven and effective way to recuperate, focusing jointly on what is most important at that moment, thereby improving team functionality. Each tactical reflection should end with everyone assessing their own stridsvärde.

Cooper's colours is a concept developed to explain levels of awareness. Although it is most often used as a method to teach and increase situational awareness in self-defence and tactical scenarios, it can also be used to learn how to decrease situational awareness and, subsequently, the stress and fatigue resulting from high levels of awareness. The system, as devised by Colonel Jeff Cooper, can be loosely summarised as:

- White: Relaxed, unaware, unprepared;
- Yellow: Relaxed, prepared, aware.

Good situational awareness;

- Orange: Identified potential threat. Ready to act or take evasive action; and
- Red: Taking action, high alert, actively engaged.

This concept was implemented as a tool to help staff and management distinguish levels of awareness and tension.

Relaxation and breathing were another area of focus: ICU staff and management were taught simple relaxation techniques in order to lower their stress levels, both at the bedside and during breaks.

It is important to understand stress. For this reason, psycho-educative training – short lectures in order to understand both acute and accumulated stress, as well as the adequate reactions to stress and fatigue – were provided to both staff and management. Initially, the fear of fear itself was just as problematic as the reactions to stress and fatigue.

Staff and management were introduced to the combat operations stress control (COSC) concept.

Leading under pressure was another area of development – ICU management personnel were trained and mentored in the basic principles of stress reducing leadership, leading under pressure and crisis management.

In addition, ICU management staff were taught how to weaponise ethics. In other words, they learned how to reduce the stress induced by staff worrying about healthcare ethics and not being able to reach all the high pre-Covid standards that they previously worked towards. Managers were mentored how to communicate a 'clear line of sight' through the complex ethical problems caused by the pandemic.

Finally, a situation room was quickly established. This provided an easily accessible physical venue that was open to all. It was here that the common operational picture was produced and the daily sitrep briefs were held. All of this also enabled an overview of the situation – the resources and challenges, as well as the success stories.

Taking stock, we have to conclude that there has been a lack of available knowledge-based and adapted measures for personnel care during the pandemic. The reason is not that this knowledge does not exist. Our only conclusion is that there has been little or no application of experience from other contexts of dealing with and relieving the stress that is particular to a long-term crisis, unlike crisis management, which is usually focused on the aftermath of a specific point event.

The pandemic response is not a single point in time; that point has turned out to be a line reaching far into a distant, unspecified timeframe. When working in such conditions, efforts in addition to those that have been made available up until now are most definitely required. CRJ

Author

MAGDALENA R LIND *is co-founder of Metis Services AB and expert in human security, crisis management and resilience. She is co-author of* Come Back Alive, *a handbook for personal security in high-risk contexts*

Personnel were taught relaxation techniques to lower their stress levels, including giving massages to their colleagues during breaks

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