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Not on My Watch: Moral Trauma and Moral Injury Among Combat Medics

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NOT ON MY WATCH:
MORAL TRAUMA AND MORAL INJURY AMONG COMBAT MEDICS

by

COURTNEY BENSHOOF

Under the Direction of Dr. Kathryn McClymond, PhD

ABSTRACT

Combat medics' personal identities can become indistinguishable from the professional responsibility they have to provide care to a particular group, as a result of the official training and unofficial acculturation they receive in the military. This constructs an intensified moral world in which medics live for a time and sets the stage for a specific kind of moral experience in combat, one grounded in a sense of personal responsibility for the physical well-being of their comrades. When combat medics are unable to fulfill their professional role, this can cause a distinct form of moral trauma, because they have also failed to fulfill a personal sense of purpose.

INDEX WORDS: Moral Injury, Veterans, Combat Medics, Trauma, Army, Oral History, Identity, Military

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

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TABLE OF CONTENTS

ACKNOWLEDGMENTS	v
LIST OF FIGURES	vii
1 INTRODUCTION	1
2 DATA.....	3
3 POPULATION.....	5
3.1 Role of Identity	10
3.2 Results of Combat Medic Training.....	13
4 MEDIC CULTURE	15
4.1 A Distinct Class.....	15
4.2 Ingroup Identification and Treating Friends	16
4.3 Creed, Motto, and Oath.....	22
4.4 Resulting Moral Trauma	25
5 MORAL INJURY.....	27
6 CONCLUSION.....	32
REFERENCES.....	37
APPENDIX.....	39

LIST OF FIGURES

Figure 1: 6
Figure 2: 8
Figure 3: 11

1 INTRODUCTION

The last words of a military brother who dies in your arms, haunts you daily. No matter what the autopsies say or what my knowledge of traumatic wounds are, I still question myself; did I do the right thing? Should I have done something different?¹

This quote, taken from an article written by two Army Ranger combat medics, highlights the moral anguish that a medic may feel when a patient “dies in your arms” during combat. The article goes on to describe the intense bond between those who served together, the drive they felt to always do more, and the simple fact that those whose lives were not saved were unlikely to leave the memories of those who were there to save them – all of which are elements which contribute to the medic’s unique experience of moral trauma. The central argument of this thesis begins with the assumption that combat medics fulfill a professional role that carries with it a personal moral obligation. For many, this responsibility becomes attached to an identity through the training that medics receive. A medic is trained to perform the very specific action of medical healing, and because of how the medic is enfolded in her² community, this ability to act to heal becomes attached to her personal identity to such an extent that it informs her morality. This culminates in a sense that one’s ability to act to heal becomes critical to the personal moral identity of a combat medic. Consequently, feeling unable to heal, which can be expressed as uselessness in a combat scenario could potentially lead to moral trauma if the inability to act shakes the medic’s sense of self sufficiently.

The types of trauma that a combat medic may experience will be different than those of regular infantry, as a medic is faced with the distinct challenge of being expected to address the

¹ Andrew D. Fisher and Leo Jenkins, “Ranger Medic: Drive for Perfection,” *The Havok Journal*, July 17, 2014, accessed Feb. 16, 2016. <http://havokjournal.com/culture/the-drive-of-the-ranger-medic/#>.

² Though all of the quotes that I have chosen to include in this thesis come from male combat medics, this position is open to both women and men. Therefore, when describing medics, I will use both the male and female pronouns. The opening of this position to women is a modern change, and therefore in most oral history archives, the majority of the combat medic interviewees are male.

injuries of a fellow soldier while simultaneously navigating the hazards of a war zone³. A medic's job is to heal wounded soldiers, so what is the result when she fails to serve her purpose during combat? And how can moral injury research help caretakers provide better care to these specific veterans? These are some of the questions that this thesis will attempt to address. My review of the data will demonstrate that the training and distinct experiences of combat medics set them apart from other military populations by creating an intertwined personal moral identity and professional responsibility. If something occurs and a medic is not allowed to fulfill this responsibility, she may articulate this professional failure in terms of moral failure. This makes moral injury a useful category for understanding combat medic trauma. Moral injury is an intense inner conflict characterized by profound guilt and shame that arises as a result of a severe betrayal of what's right and that interferes with normal functioning in everyday life. This thesis will argue is that medics may express moral injury in terms of professional failure, uselessness, or helplessness. This is opposed to more commonly recognized moral injury language that may include explicit expressions of guilt and shame. This is important to recognize because the way that medics may express moral injury may not be recognized under current descriptions and could prevent medics from receiving proper treatment. By studying this group, we can see that not everyone will experience, or express, moral injury in the same way.

I will first describe the dataset that makes up the backbone of this research, and then will go on to describe the training and culture of combat medics. I will pay particular attention to the training that shapes how medics may understand themselves and their roles and responsibilities in the context of combat, as well as the impact of combat medic culture, on their sense of

³ Clearly, the other soldiers in the same unit may experience traumas of their own, however, throughout this thesis I will be focusing on the nature of the trauma that a combat medic may experience. This is not to say that the trauma suffered by one group is any way more significant than that of any other group.

identity. Then, I will present some background information on moral injury to highlight the conversational background of this topic. Throughout this paper, I will reference the words of several combat medics describing their own experiences, alongside an analysis of the factors that may have bearing on these experiences.

2 DATA

For this research, I reviewed fifty-seven oral history interviews across seven archives.⁴ I began my research in the Veterans History Project archives of the Atlanta History Center and the Library of Congress, along with the Veterans History Project provided by the Louie B. Nunn Center at the University of Kentucky. I then expanded my search and found veteran's history projects at Rutgers University, Texas Tech University, the Texas Veterans Land Board, and the New York State Military Museum. Each of these archives offered varying levels of accessibility and functionality, depending on how the interviews were organized and the format of each specific site. For instance, archives that were searchable or capable of being narrowed were much more useful than those which were not; and archives which offered video, audio, and transcript versions of their interviews were the easiest to examine in depth.

This research provided me with a view into a broad segment of this population. My dataset is made up of both officers and enlisted personnel, with ranks ranging from Private to Lieutenant Colonel. Of the fifty-seven interviews that I reviewed, twenty served in World War II, fourteen in Vietnam, one in Korea, three in the Gulf War, and nineteen in Operations Enduring Freedom and Iraqi Freedom. Forty-two interviews were with male veterans, and fifteen were with female veterans. Of these, twenty-four served as combat medics in an active war zone.

⁴ For a list of the archives I accessed and how to find them, please see the Appendix.

The rest were other members of the military medical community such as physicians, nurses, physician assistants, hospital administrators, dentists, surgeons, mental health providers, and medevac pilots. The variety and breadth of the experiences detailed within these interviews was key to the insights presented in this thesis.

From the interviews, I was able to learn about the veterans' remembered experiences and what kind of life stories they had constructed around them. Research on oral histories allow us to see how a veteran has remembered and made sense of an event, and the use of this methodology will allow for the evaluation of the experiences of veterans through their own language. Obviously the data that has been drawn from these sources is idiosyncratic, but these histories offer helpful insight into some difficult experiences.

I also reviewed multiple published memoirs written by combat medics. These documents provided a different type of information than what was available through oral history. The memoirs provided some fact-checked information about the events that had taken place during the conflicts that veterans spoke about in their interviews. These were often presented as a first-person narrative, much like the recorded interviews, but the memoirs added an element of context that was more difficult to attain in an interview. The memoirs gave me a skeleton of verified information and thoughtful narration upon which I could build with the less-structured accounts presented in the interviews. Both sources were necessary in order for me to develop a more comprehensive understanding of what makes the experiences of combat medics distinct.

One potential criticism of the use of oral history in research is that this data is inherently reliant upon the memory of the speaker, and memory is not an entirely reliable source if one is interested in learning specific facts about a time or an event. However, for this project, more important than the accurate recounting of facts is the meaning that the speaker constructs from

his experiences. What is gained through oral history is valuable precisely because it is a constructed narrative. Dan P. McAdams, a modern scholar of personality and developmental psychology, illustrates this point when he explains, “I ask people to tell me the stories of their lives because I believe their verbal accounts hold the outlines of internalized personal myths,”⁵ and “a personal myth delineates an identity.”⁶ These stories represent how an individual has made sense of an event that happened to him or in which he participated and how he has or has not integrated that event into his identity. By nature, the story that he tells will not be complete, and it is unlikely to be remembered in the same way by someone else – this makes it extremely useful for research on the morally traumatic experiences of the individual. Moral trauma can result when an individual’s ideologies concerning the way things ought to be are betrayed, and this was something that I looked for specifically in reviewing these oral histories.

3 POPULATION

This paper focuses on the experiences of combat medics, as this group holds a unique position within the military establishment. Medics are often personally – and sometimes deeply – connected to their patients. This connection occurs consistently, and can result in the medic losing her ability to remain objective, with the possibility of increased feelings of guilt or shame should the medic fail to live up to her responsibility of saving lives. Further, medics function as a fully integrated member of a unit rather than being a step removed from conflict as are other military medical providers. In a war zone, medics endure the same hardships as their non-medical comrades, with the added expectation that they will be able to function as a medical

⁵ Dan P. McAdams, *The Stories We Live by: Personal Myths and the Making of the Self* (Guilford Press, New York, NY, 1993) 20.

⁶ *Ibid.*, 34.

provider when necessary. In contrast, other medical providers operate from relative safety and are typically unacquainted with their patients.

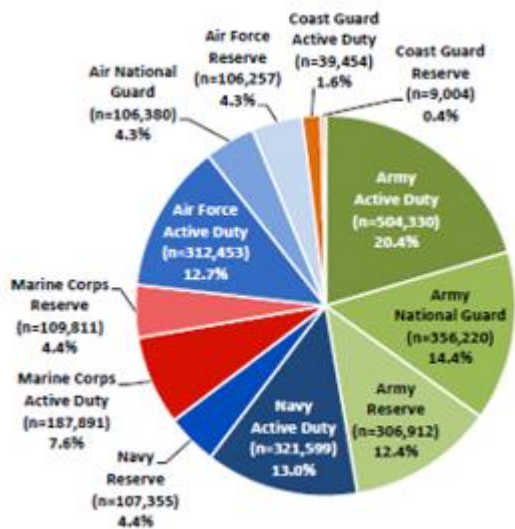


Figure 1: Active Duty and Reserve and Guard members of the Army make up the largest percentage of military personnel (47.3%).

Note: Percentages may not total to 100 due to rounding.
Source: Official Guard and Reserve Manpower Strengths and Statistics FY 2014 Summary.

This thesis focuses primarily on Army combat medics (though there are equivalents in other branches of the military) as Army medics make up the largest portion of in-field medical providers. This is due to the fact that Army personnel in general make up the largest portion (47.3%) of military personnel (see Figure 1). Every year, the Office of the Deputy Assistant Secretary of Defense publishes a demographics profile of the US military community. As of 2014, the date of the

publication of the last military demographics profile, the total number of active duty military personnel was 1,326,273, with 504,330 of these serving in the Army.⁷

In the decades since the United States ceased the practice of conscription, a typical Army medic's journey begins in a recruiter's office, where a young man or woman signs a document, swears an oath of enlistment, and becomes a member of the armed forces. He then undergoes ten weeks of Basic Combat Training (BCT), which is the same for every soldier regardless of specialty. These ten weeks consist of instruction in "basic tactical and survival skills along with how to shoot, rappel, and march. He will also learn the basics of Army life and military customs,

⁷ "2014 Demographics Profile of the Military Community," Office of the Deputy Assistant Secretary of Defense, accessed May 25, 2016. <http://download.militaryonesource.mil/12038/MOS/Reports/2014-Demographics-Report.pdf>.

including the Seven Core Army Values.”⁸ A more intangible aspect of this stage of training involves transforming the civilian into a soldier. Robert Shippen, a Special Forces Medic who served in Vietnam, remembers his initial training:

...they did start conditioning us to start identifying ourselves, I mean, to condition us to accepting that we were eventually going to go there and that we were going to be in a fight. Maybe we were going to die. It’s all this—when you’re running they’ll do cadence calling, and it would be songs that talk about dying, killing, and dying and the commie, or the enemy, or the red, or something bad. So that Psy-ops [Psychological Operations] was starting to happen... You get folks going to where they’re competing with one another to see who can get killed first. But, that’s what we did.⁹

By the end of BCT, the individual has become a Soldier, with the same basic skills, uniforms, and training as other soldiers. He is encouraged to think of himself as a soldier, not a civilian.

Next is Advanced Individual Training (AIT) – a minimum of sixteen weeks of instruction during which time soldiers receive instruction in their particular field. For the research population that I studied, AIT takes a soldier and turns him into a 68W-Healthcare Specialist, also known as a 68-Whiskey, or Combat Medic. During this process the individual will become a nationally certified Emergency Medical Technician – Basic (EMT-B), as well as becoming certified in CPR and Tactical Combat Casualty Care (TCCC). During AIT medics will also learn what their responsibilities will be during combat. John Hubenthal, a combat medic who also served in Vietnam, comments:

They did talk about our mission as members of the medical corps and actually got kind of serious about that, as serious as they could get. [They said] Save lives. “You men are going to be the salvation of the American soldier.” Which boils down to, “save lives.”¹⁰

⁸ “Basic Combat Training,” GoArmy.com, accessed May 25, 2016. <http://www.goarmy.com/soldier-life/becoming-a-soldier/basic-combat-training.html>.

⁹ Robert Shippen, interview by Richard B. Verrone, Oral History Interview, Texas Tech University, May 25, 26, 2006; August 7, 10, 11, 14, 2006; September 11, 21, 22, 2006; October 6, 2006.

¹⁰ John Hubenthal, interview by Laura Calkins, Oral History Interview, Texas Tech University, December 15, 16, 21, 22, 2005, January 4, 6, 11, 20; February 6, 16, 20, 2006.

According to an Army field manual that addresses health services in a theater of war, the primary objective of unit-level medical care personnel is to provide “immediate lifesaving measures.”¹¹ Medics receive instruction in these measures from the earliest stages of AIT, up to and including their time in combat, when they may receive additional training from more experienced medics.

Once these stages of training are complete, the brand new medic can be assigned to his unit. There are many different types of “units” within the Army (see Figure 2),¹² but the most commonly referenced unit is the platoon; this is the level at which a medic can be assigned if he is to be deployed. Depending on its operational goals, a platoon can be comprised of anywhere from 16-45 soldiers, with one medic assigned per

platoon,¹³ though occasionally, more than one platoon will be stationed in the same area. As we will discuss later, this group can become very closely bonded, which can prompt the medic to feel a strong sense of responsibility for his 16-45 companions.

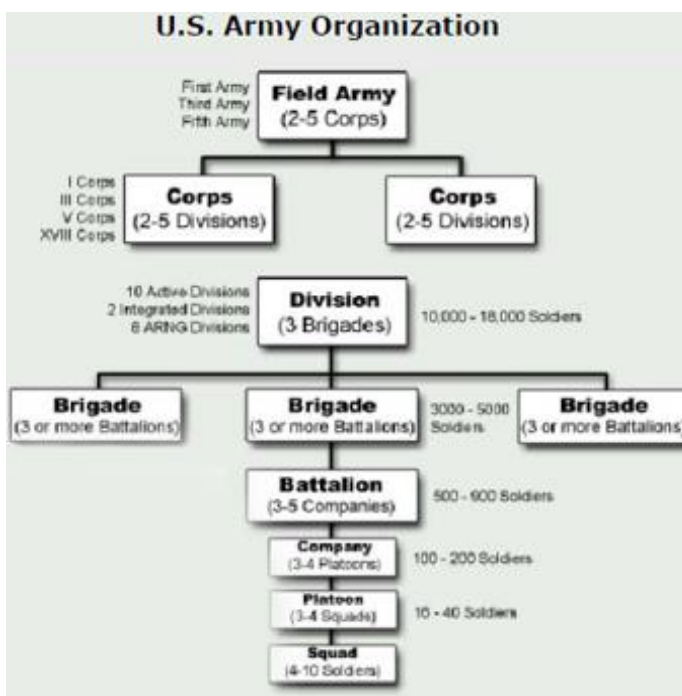


Figure 2: Note: “Squad,” “Platoon,” “Company” etc. are unit names. In this thesis, when reference is made to a unit, (e.g. “A medic is embedded with a unit...”) this is referring to the unit on the platoon level, unless otherwise indicated.

Source: Olive-Drab.com

¹¹ “Joint Publication 4-02: Health Service Support,” Chairman of the Joint Chiefs of Staff, July 26, 2012, accessed June 8, 2016, III-1. http://www.dtic.mil/doctrine/new_pubs/jp4_02.pdf.

¹² “US Army Organization,” Olive-Drab.com, n.d., accessed June 8, 2016. http://olive-drab.com/od_milorgs_us_army.php.

¹³ “Field Manual 3-21.8: The Infantry Rifle Platoon and Squad,” Headquarters – Department of the Army, March 2007, accessed June 8, 2016. <https://www.mtu.edu/arotc/cadet-portal/docs/FM3-21InfantryRifleSQPL.pdf>.

Once medics are assigned to a combat infantry unit, they endure the same hardships and witness the same horrors as their comrades-in-arms, but they also bear the added burden of being professionally and directly responsible for the lives of those around them. Raymond D. Butler, a combat medic in World War II recalls:

Suddenly, out of nowhere, I heard an excruciating scream, followed by voices yelling, "MEDIC! MEDIC! MEDIC!" And, as luck would have it, I was the only medic around...An unlucky soldier who'd stepped on a land mine had gotten his right leg blown off just above the knee, and while others stood around and watched, I was expected to handle the situation. I was terrified. I felt faint. I couldn't believe what I was seeing. I didn't really know what to do. Then I was shocked out of my stupor by a loud voice demanding, "What are you gonna do, Medic?"¹⁴

Hunter Hayes, a Navy Corpsman who served in Iraq and would frequently request to be sent on ground patrols (an unusual role for a Corpsman) notes:

...stuff like that was fine during training because you didn't know any of 'em, but getting there and it's your friend...it's a lot more personal. Imagine having to make the call to cut your friend's legs off or cut his chest open. And he's crying to you or...it's just a tough deal.¹⁵

An article that was written by two Army Ranger medics (an elite class of soldiers) explains:

I have, too often been the last person that a Ranger sees or talks to prior to leaving this earth. I have, too often had to tell my fellow Ranger Brethren about the death of one of our own. I have, too often looked into a Ranger's parents, spouse, and sibling's eyes to tell the story of how their loved one died and what I did for them in their last moments.... The last words of a military brother who dies in your arms, haunts you daily. No matter what the autopsies say or what my knowledge of traumatic wounds are, I still question myself; did I do the right thing? Should I have done something different? The screams, words, and sounds of the dying and severely wounded are always in my thoughts. The guilt weighs on me daily.¹⁶

¹⁴ Raymond D. Butler, "WWII Combat Medic's Personal Accounts of WWII," Military Transport Association of New Jersey, July 28, 2002, accessed February 15, 2016.

<http://www.mtaofnj.org/content/WWII%20Combat%20Medic%20-%20Dave%20Steinert/WWIICombatMedicPersonalAccounts.htm>.

¹⁵ Hunter Hayes, interview by James Crabtree, Texas Veterans Land Board, August 5, 2009.

¹⁶ Fisher and Jenkins, "Ranger Medic: Drive for Perfection."

The dual responsibility of combat medics for both their own lives and the lives of their friends could make this group particularly prone to situations that call for morally anguishing choices as well as experiences of uselessness. These are situations where an individual has a relevant authority of responsibility, but fails to fulfill it, leading to questions of "Did I miss something?" or thoughts of "I should have done more." Medics take on a professional role that is tied to a very specific type of action - they feel morally responsible to save a life. When they feel that they are useless or helpless, or that there is nothing that they can do, the sense that they have failed in their responsibility can affect them on a moral level. This is further complicated as the medic's professional role becomes a personal identity.

3.1 Role of Identity

Through rigorous training, medics are taught to internalize a personal identity that revolves around their agency and abilities, so much so that it becomes a way of life, and much more than just a job. Though it would be impossible to make a claim about how all medics think of themselves, it is possible to describe how the military *encourages* them to think and identify, and that training can be very effective. Joshua Fansler, a medic with the 82nd Airborne in Iraq and Afghanistan, says of completing medic training:

I hurt, froze, and sucked it up, but through it all, I became a Combat Medic. It now became so much more than a uniform change; it was a way of life...I will forever be an 'Airborne Medic.'¹⁷

There have been decades of extensive research into how an individual constructs her identity.

This project focuses on the theories presented by Dan P. McAdams. McAdams' research explores the idea that a person's identity is analogous to her "life story,"¹⁸ and that we develop

¹⁷ Joshua R. Fansler and Joshua M. Peters, *Not on My Watch: The 21st Century Combat Medic* (AuthorHouse, Bloomington, IN, 2005), 8.

¹⁸McAdams, *The Stories We Live by*, 5.

an understanding of who we are and how we fit into the world as our life stories progress. Specifically, “a life story is a personal myth that an individual begins working on in late adolescence and young adulthood in order to provide his or her life with unity or purpose and in

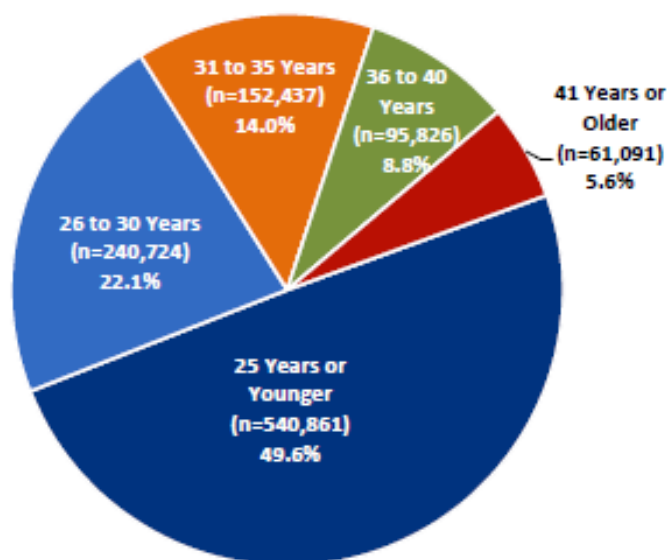


Figure 3: Active duty enlisted members by age group. Approximately half (49.6%) of Active Duty enlisted personnel are 25 years of age or younger, compared to 13.4 percent of Active Duty officers.

Note: Percentages may not total to 100 due to rounding.

Source: DMDC Active Duty Military Personnel Master File (September 2014)

order to articulate a meaningful niche in the psychosocial world.”¹⁹ This scholarship presents a useful way to interpret oral histories, as these are constructed life stories. Particularly relevant for this paper are McAdams’ ideas concerning the type of identity development that an individual goes through during late adolescence and early adulthood, which is the typical age range for new military recruits.

Per the 2014 military demographics report, the total population of the American military is over 3.5 million, including active duty, reserves, and Department of Defense civilian personnel. From this group, “nearly one-half (49.6%) of Active Duty enlisted personnel are 25 years of age or younger, with the next largest age group being 26 to 30 years (22.1%).”²⁰ Thus, as of the date of the last demographics profile, approximately 72% of the population of the US armed forces is under the age of 30 and qualify as members of the late adolescent/early adult

¹⁹ Ibid.

²⁰ “2014 Demographics Profile of the Military Community.”

data set. According to McAdams, these are “particularly formative periods in the life span”²¹ during which time the individual is working to solidify her personal ideologies.

Ideology “implies an abstract and systematic outlook on the world and the human being’s place in it”²² and the formation of ideology “presupposes the ability to reason in an abstract manner so as to conceive of hypothetical systems concerning what is and what ought to be.”²³ However, under the influence of a rigid military program, with its unifying creeds and transformative rituals, adolescents and young adults may abdicate their own fledgling conceptions of “what is and what ought to be” in favor of those in which they are immersed. The timing and intensity of military training can cause military ideology to become personal ideology. Occasionally, they are even cognizant of this abdication:

[On entering military training] I was leaving behind, forever, a way of life, an identity, a personality, and all that I cherished and held sacred for the past twenty-one years.²⁴

They may even be aware of the consequences that this choice will have on their lives after the military. John Hubenthal admits:

I mean civilian life...I hadn’t even begun to figure out adult civilian life. I’d never experienced it. Went straight from being Mom and Dad’s kid to the war and, boom! Back out again.²⁵

Though accepting this collective identity may lead to potential negative results later in life, this transition is extremely useful for creating and maintaining loyalty and group cohesion, two concepts which are crucial to military efficacy.²⁶ By the end of an extensive military training process, the individual has become a Combat Medic, ready to be assigned to a unit and ready to

²¹ McAdams, *The Stories We Live by*, 312.

²² Ibid.

²³ Ibid.

²⁴ Brock, *Soul Repair*, 19.

²⁵ John Hubenthal, Oral History Interview, Texas Tech University.

²⁶ “Field Manual 3-21.8: The Infantry Rifle Platoon and Squad,” p. 1-25.

be given the opportunity to live up to her heightened sense of responsibility. Robert Shippen recalls completing training:

I had joined. This was what my society wanted to do with me. I was willing for it to do whatever it wanted. I had actually made it into Special Forces. I actually had. I made it all the way. Not only that, I was a medic. By this time, I had identified myself as a medic and I was hot to trot...I'm ready to stop the bleeding, to clear the airways, to do a cricothyroidotomy. I'm ready.²⁷

3.2 Results of Combat Medic Training

Through extensive training, medics develop expectations of themselves, which are reinforced by the dependence of their peers during combat. A combat medic's role is to administer medical aid to wounded soldiers in battle and to "conserve the fighting strength."²⁸ When a medic is deployed to a combat zone, he understands that it is his responsibility to be ready and able to respond when someone cries out "Medic!" Oral history interviews indicate that some amount of guilt and shame may be the result if the medic fails to live up to this responsibility.

Dr. Jonathan Shay argues that "combat calls forth a passion of care among men who fight beside each other,"²⁹ and this is a sentiment that was overwhelmingly present in the interviews that were a part of the research for this project. One Marine who served in Vietnam explained that he "felt an overwhelming burden of responsibility, no longer to Corps and Country, but to those whose lives depended upon [his] abilities and decisions."³⁰ According to Shay, this bond occurs naturally in certain contexts, but it could be specifically reinforced by combat medic training, which imparts the knowledge of a medic's responsibilities. Robert Shippen explained:

²⁷ Robert Shippen, Oral History Interview, Texas Tech University

²⁸ Fansler and Peters, *Not on My Watch*, xix.

²⁹ Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (Scribner, New York NY, 1994), 39.

³⁰ Brock, *Soul Repair*, 20.

[On training] ...it just impressed upon me the importance of paying attention and not making a mistake and how important what I was doing was. That it was just a lot of responsibility that I was going to have.³¹

This was supported by Hunter Hayes:

...having that responsibility of saving somebody's life is a pretty big deal, and sometimes you get to the point where you don't think anybody else can do it but you. So you sacrifice so much, you know what I mean?³²

As well as John Hubenthal:

You're trying to keep somebody alive in a situation that's designed to kill them...that's a hell of a responsibility.... These guys were going to live and were going to make it through because of me and I was responsible for the health and well-being and survival of a platoon of guys, and for a brief period for a company of guys. And how could I not take that seriously?³³

The focus of the training that medics undergo is geared towards creating competent life-savers.

This occupation is active in a very specific way. Just like the soldiers around them, medics have been armed with certain tools and skills, but in the case of the medics, they are specifically expected to use these tools and skills to save the lives of their friends – they are expected to act to save lives and to be successful in that action. Further, trusting in one's own knowledge and abilities is crucial. Though “medics often face self-doubt — an emotion they must hide or risk losing the platoon's confidence,”³⁴ medics expect themselves to work with efficiency and capability while projecting certainty and self-assurance. To express doubt, a natural emotion under such intense pressures, would require an admission of vulnerability, and for some medics “it is incredibly difficult to open up, to admit that there is a crack in our emotional armor.”³⁵ As the medic mentioned above, this type of visible fallibility could cost them the confidence of their platoon, which could lead to the loss of their identity as a medic. Thus, combat medics learn to

³¹ Robert Shippen, Oral History Interview, Texas Tech University.

³² Hunter Hayes, Oral History Interview, Texas Veterans Land Board.

³³ John Hubenthal, Oral History Interview, Texas Tech University.

³⁴ Seth Robbins and Steven Beardsley, “Study Looks at Psychological Effects Suffered by Combat Medics,” *Stars and Stripes*, September 16, 2011, accessed May 23, 2016. <http://www.stripes.com/news/study-looks-at-psychological-effects-suffered-by-combat-medics-1.155272>.

³⁵ Fisher and Jenkins, “Ranger Medic: Drive for Perfection.”

rely heavily on themselves, carrying the weight of both a warrior and a healer. Hunter Hayes describes:

I think we all understand, as people in the medical field in the military understand, that these are things that we're going to have to live with for the rest of our life. It is something that we accept and we deal with. We suck it up.³⁶

The understanding that Hayes asserts refers to is the gap between fulfilling and failing one's responsibility. He is both admitting that it is impossible for a medic to live up to his professional responsibility every time, and acknowledging the personal cost of such inevitable failure. This situation can be isolating, and is a potential contributor to the higher prevalence of depression among medics as opposed to other soldiers.³⁷ Medics are trained to accept an identity that revolves around their responsibility to carry out life-saving action, but this alone would not distinguish them from other military medical providers. The distinction is achieved when one understands this identity in conjunction with some other factors at play in medic culture.

4 MEDIC CULTURE

4.1 A Distinct Class

Combat medics are part of a unique official classification of military personnel. The first Geneva Convention was published in 1949 by the International Committee of the Red Cross.³⁸

Per the Conventions: "All members of the armed forces of a party to the conflict are combatants,

³⁶ Hunter Hayes, Oral History Interview, Texas Veterans Land Board.

³⁷ According to a study concerned with access to mental healthcare for returning veterans, "7.9% of US Army Soldiers screened positive for depression compared to 15% of US Army Soldier Medics." From: Paula L. Chapman, et al., "Mental Health, Help Seeking, and Stigma and Barriers to Care Among 3- and 12-Month Postdeployed and Never Deployed U.S. Army Combat Medics," *Military Medicine*, 129, 61, 2014.

³⁸ "The Geneva Conventions of 1949 and their Additional Protocols," International Committee of the Red Cross, January 1, 2014, accessed June 16, 2016. <https://www.icrc.org/en/document/geneva-conventions-1949-additional-protocols>.

except medical and religious personnel.”³⁹ The rules governing conflict are in place as protections – in the event that medical or religious personnel are taken as prisoners of war, their noncombatant status should allow them to continue to care for their fellow detainees. The primary distinction between combatants and noncombatants is that medical and religious personnel are to be unarmed except for a personal weapon such as a pistol, and are not to be targeted during combat. Medics are permitted to carry a personal weapon to be used in self-defense or in defense of their patient,⁴⁰ though they are not to participate in active combat in pursuit of strategic goals. This is to say that combat medics are truly, and legally, distinct from their combatant-class companions. This continues to be evident when one examines the dynamics at play within a unit.

4.2 Ingroup Identification, Identity Fusion, and Treating Friends

In his book *Achilles in Vietnam*, Shay discusses the “passion of care” that develops between soldiers during combat. In the oral history research that was conducted for this project, having – or being unable – to provide medical care to one’s close personal friends was the most frequent source of anguish following a failure to fulfill one’s responsibility. Stephen Presser, a combat medic in Vietnam recalls:

This is a fellow medic; he was my best friend. One day I was called...for some reason I was back in the rear that day. [They] sent a helicopter for me to go out into the area where they were having contact. Well, I got out there...and they said "Did you hear about Jerry?" I said "No. What's going on?" Well he pointed in that direction over there and said "He was shot between the eyes and never knew what had happened to him." And that...was my friend.... At the time that they told me he died, right after they told me that, we started having incoming. That was the most traumatic experience I remember, even when I was being shot at before or afterwards, it didn't hit me like that one did. I began to tremble, my teeth were chattering, and I couldn't stop it. I was completely useless. And I was praying to God that no one would holler "medic," because I didn't know what I could do...I've never been that frightened before, and I hope I'm never that

³⁹ “Definition of Noncombatants,” International Committee of the Red Cross, accessed March 23, 2016, my emphasis. https://www.icrc.org/customary-ihl/eng/docs/v1_cha_chapter1_rule3

⁴⁰ “Definition of Noncombatants,” International Committee of the Red Cross.

frightened again. It was like the world had crashed. Ya know, the world as I knew it was gone. It was overwhelming, I was just overwhelmed.⁴¹

Likewise, Alberto Sanchez Bonifacio, a medic for a military police unit in Afghanistan and Iraq:

Two main things that occurred that I think really shaped, not just my military experience, but who I am as a person [pause] the death of two of my colleagues. Um, one of my friends, he was a good friend, he was actually my only friend in Greenville that came from the same town that I was from, died in a [inaudible] and I was the medic on duty. I tried to revive him but, uh, his Humvee collided with a tank at night. And then my other friend, um, it was about twelve hours before he was supposed to, um, return home on a plane, actually got hit by a rocket, and died, twelve hours from coming home. Those two events, ya know, I think about those still. I don't think about it a thousand times a day anymore, but I think about it pretty, pretty regularly...⁴²

Arthur Wenzel had a similar experience:

The fellow, the first one I had to treat...was a buddy of mine. His head was so ripped back; I didn't know how to take care of it. I didn't know where to start... Yes, my own buddy, the one who had his head practically blown off, his scalp removed, just a flap there. Yes, I took him right back to the ship, carried him back.⁴³

This is not to say that medics can only be traumatized by events involving close personal friends.

In fact, there are dynamics at play within a combat unit which encourage a medic to think of all of his comrades with the same "passion of care." Raffield et al. explains the concept of ingroup identification:

Ingroup identification is a process of social categorization in which a particular ingroup is included in an individual's concept of self ... a high level of ingroup identification can have a significant effect on group cohesion and performance... Individuals who identify strongly with an ingroup are also more likely to pay attention to the manner in which their group is dealt with compared to other groups, to incur a personal cost to benefit their group and to stay faithful to their group when it is imperiled.⁴⁴

Raffield shows that ingroup identification can generate close bonds with all of those whom the medic is called upon to assist. Identity fusion takes this bond a step further. In certain

⁴¹ Stephen Presser, interview by Joe Brukner and Tony Hilliard, Oral History Interview, Atlanta History Center, September 9, 2011.

⁴² Alberto Sanchez Bonifacio, interview by Andrew Kuo, Oral History Interview, Library of Congress, n.d.

⁴³ Arthur Wenzel, Oral History Interview, Rutgers University.

⁴⁴ Ben Raffield, Claire Greenlow, Neil Price and Mark Collard, "Ingroup identification, identity fusion and the formation of Viking war bands," *World Archaeology*, 48(1): 37-38, 2015.

circumstances, “visceral and emotional relationships can develop among ingroup members, leading them to identify with one another as if they were kin.”⁴⁵ This is known as identity fusion.

An article by William B. Swann and Michael D. Buhrmester explains the role of identity fusion in pro-group behavior:

Upon developing a visceral feeling of “oneness” with the group, strongly fused persons retain their sense of personal agency and channel it into pro-group action. Further, rather than focusing on the collective at the expense of fellow group members, strongly fused persons regard other group members as “family” and derive a sense of invulnerability from them.⁴⁶

Thus, identity fusion in a military unit can replicate the feeling of familial ties between the medic and his ingroup, even if the medic does not have close personal relationships with his patients.

Swann and Buhrmester also allude to the significance of “personal agency” in identity fusion.

They explain that with strong ties of identity fusion, “the personal self can motivate pro-group behavior by channeling personal agency into pro-group action.”⁴⁷ The idea that an individual may find himself motivated to act – specifically, to act to heal – to support his ingroup was strongly supported by the research conducted for this thesis.

The challenging circumstances of the military are a precise example of a situation where identity fusion may occur, as sharing traumatic experiences can contribute to identity fusion⁴⁸.

Applying these theories to a combat context, these are situations where a medic has bonded with his unit to the point where he is willing to put himself in danger for a group member because he thinks that's what he owes to the unit, but he's also been training that that is his responsibility - whether or not the patient is a friend. This was supported by Hunter Hayes:

⁴⁵ Ibid., 37.

⁴⁶ William B. Swann and Michael D. Buhrmester, “Identity Fusion,” *Current Directions in Psychological Science*, 24(1): 52, 2015.

⁴⁷ Ibid., 53.

⁴⁸ Raffield, “Ingroup identification, identity fusion and the formation of Viking war bands,” 37-38.

There's not a guy that I served with that I wouldn't die for, you know, and I would do anything for each and every one of them. We laughed a lot, we were there for each other, [and] we fought a lot, which is understandable. You really get to know somebody.⁴⁹

The training the medic has had up to this point has been leading him to where, in a moment of crisis, he feels responsible for his platoon members' physical well-being and survival, and he is willing to do anything to fulfill that responsibility. If something occurs and he is not allowed to fulfill this responsibility, the medic may articulate this professional failure in terms of personal uselessness. In addition, this failure would have some impact on his sense of identity – because what has been betrayed is not just a job, but the membership and bond of his particular ingroup.

Psychologists have considered these two phenomena – ingroup identification and identity fusion – to be involved in the development of loyalty to a group, and they are particularly relevant to the military. In military units, ingroup identification and identity fusion can lead to exceptionally strong ties between members of the unit, regardless of whether members of the group subjectively *like* one another. Regardless of the quality of the relationship between the medic and soldier off of the battlefield, the medic is expected to respond with the same focus and skill to every wounded soldier. John Hubenthal explained:

I was the medic and those were my guys and my *raison d'etre*, my reason for breathing, was to take care of my guys and that's about as far as my thought process went... You know, these were my guys and it didn't even matter if I particularly liked them. There were a number of them I didn't like... These guys were going to live and were going to make it through because of me and I was responsible...⁵⁰

Because of the intense bond that forms within an ingroup, when the situation calls for it, the medic is trained to set his personal feelings aside and treat the patient to the best of his ability. Often, medics are often called upon to place themselves in harm's way in order to aid a wounded comrade. Again, John Hubenthal:

⁴⁹ Hunter Hayes, Oral History Interview, Texas Veterans Land Board.

⁵⁰ John Hubenthal, Oral History Interview, Texas Tech University.

I spent months being the man who walked between the raindrops. Somebody got out in front and got hit I went and got him. And that's why they used to touch me for luck because I did go get them and I got them back and I never got hit.⁵¹

James Essig, a frontline medic during WWII, agreed:

My job was to go out there where things were happening, and give first aid right on the battlefield to these people... I think the worst decisions, the worst things of all, were carrying people.⁵² We did that, but, we had to choose. Who could we help the most? We gave whatever first-aid we could, and then, we had to move them back quickly, to get more advanced aid in the rear. This was difficult. This was hard. You had to make a decision there pretty fast, and, many a time, you are making it, you're under fire.⁵³

The same sentiment was expressed by Arthur C. Wenzel:

We served as the frontline medics and we're also litter bearers, because we had to get them back to a certain point. Somebody had to get them back. As a rule, you had your head down, trying to either dodge shells or else take care of somebody or evacuate him.⁵⁴

The consideration of military training and ingroup dynamics helps explain how and why a medic would put himself in this level of danger. Further, as there is only one medic assigned per platoon, the medic is often expected to function without aid in a combat scenario. If a medic is called to the side of an injured comrade and the individual dies despite the medic's best efforts; or if the individual dies due to an outside factor that prevented the medic from performing to the best of his abilities, the medic may then carry the weight of this professional failure to fulfill his responsibility as a personal moral failure. This experience is made more traumatic by the bonds that are formed between the medic and his patients. Take, for example, the experience of Alberto Sanchez Bonifacio:

I was proud to be a medic, and I still am. I thought it was the best job in the world. We sunk every sinew, every fiber that we had and risked our lives with one pure mission, which was to make sure that our guys came home alive. And one doesn't make it? That violated everything that we tried to do. And I remember that for my friend's funeral, I ripped my medic brassard off of my sleeve and said I will never treat another patient,

⁵¹ Ibid.

⁵² Referring to physically carrying injured soldiers off the battlefield. They could only take so many at a time, so they were forced to leave some behind, and had to choose who got to go and who had to stay.

⁵³ James Essig, interview by Kurt Piehler and Scott Ceresnak, Oral History Interview, Rutgers University, November 17, 1997.

⁵⁴ Arthur C. Wenzel, Oral History Interview, Rutgers University.

ever. The burden is too high'. It was way too much for us to bear, when you tried this hard and things didn't happen like they were supposed to.⁵⁵

Some medics come to the conclusion that close friendships between themselves and their comrades could only lead to pain, so they detach personally, while maintaining the “passion of care” that allows them to do their jobs. As was recalled by John Hubenthal:

I made it a point not to make friends after about my first two months. I didn't get real close in terms of being pals with the soldiers I was responsible for. That was a kind of knee-jerk response. It was nothing conscious about it. I just concluded that if I was going to have to put these guys in a body bag I didn't want to be emotionally close to them, but I was in this funny way. They were mine. They were, you know, by God, if I had anything to say about it they were going to get through it and that was my job.⁵⁶

It could be useful for a medic to retain a level of emotional separation from his patient, as objectivity aids focus. However, according to Raffield, “any ideological or ritual aspects of ingroup identity could well have contributed to the greater potential for identity fusion, which in turn would have been strengthened by shared experiences of combat.”⁵⁷ Thus, due to the identity fusion that often takes place among the ingroup of a military unit, the sense of responsibility that a medic feels towards his comrades could be weightier even than those who find themselves treating their closest friends. This can make the bond of the ingroup difficult to escape, but the medic can attempt to avoid close personal friendships, as these carry the greatest risk of emotional trauma.

Combat medic training encourages individuals to identify personally with their ingroup, which on a large scale could be all of their fellow soldiers, and on a smaller scale could be other combat medics. Then, these new medics are placed with a group of people and are told that the lives around them are their responsibility. The dangerous nature of combat creates a high-stakes

⁵⁵ Alberto Sanchez Bonifacio, Oral History Interview, Library of Congress.

⁵⁶ John Hubenthal, Oral History Interview, Texas Tech University.

⁵⁷ Raffield, “Ingroup identification, identity fusion and the formation of Viking war bands,” 43.

situation that contributes to identity fusion on a group level and the formation of a new ingroup comprised of the members of the unit. Add to this the traumas that frequently occur in a war zone and there will be a high likelihood that the participating group members will find themselves closely bonded to one another. This bond can cause members of a unit to “develop a strong sense of obligation and commitment to the group, leading them to act altruistically, sometimes to the point of sacrificing their lives for other members.”⁵⁸ For an individual who is willing to “do anything” in order to fulfill his responsibility of saving the lives of others, particularly those with whom he is bonded, a failure to fulfill this responsibility could result in a distinctly moral experience.

4.3 Creed, Motto, and Oath

As McAdams notes, the years of late adolescence to early adulthood are often the years that an individual spends discovering her own personal identity. This typically occurs once an individual has left home and is enjoying the relative freedom of college or the workforce. But in certain settings, “identity is conferred upon the young person by a social structure,”⁵⁹ and these sociocultural systems are often buttressed by oath-taking and group-specific ideologies.⁶⁰ The U.S. military is perhaps one of the greatest promulgators of this type of rhetoric heavy identity-conferring system. For example, as a form of ethics training, all soldiers receive instruction in the Core Warrior Values. These are loyalty, duty, respect, selfless service, honor, integrity, and personal courage, and represent the characteristics that every soldier is to possess.⁶¹ Certain other aspects of military training and culture, such as the acceptance of creeds and the swearing of oaths, work towards the solidification of ingroup bonds. Medics are exposed to multiple

⁵⁸ Ibid., 38.

⁵⁹ Dan P. McAdams, *The Stories We Live by*, 82.

⁶⁰ Raffield, “Ingroup identification, identity fusion and the formation of Viking war bands,” 36.

⁶¹ “The Army Values,” Army.mil, accessed August 15, 2016. <https://www.army.mil/values/>.

examples of this rhetoric. As soldiers, they swear an oath of enlistment when they join the Armed Forces, and during training they internalize the Medic Motto of “Not on My Watch,” and may come to identify with the Combat Medic Creed. Each of these can serve the purpose of ensuring the acceptance of a specific identity.

According to Raffield, “because oaths served to create strong ties of obligation and loyalty among otherwise unrelated individuals, they would have reduced barriers to ingroup cohesion. The links created by oath-taking also had the potential to become more visceral through identity fusion.”⁶² This theory fits the practices of the military. With the aid of specific oaths, mottos, and creeds, each unique to the group by which it is borne, the military fosters identity fusion which aids in the formation of kin-like alliances on multiple scales.⁶³ Most enlisted persons will remember when they swore in the Oath of Enlistment to “support and defend the Constitution of the United States against all enemies, foreign and domestic.”⁶⁴ This type of pervasive rhetoric can become the yardstick by which medics measure themselves. Fansler explains this phenomenon in his discussion of the Medic Motto:

“First, our motto: Not on My Watch. This speaks not only of the personal pride and sacrifice that we, as Combat Medics, have in our assignment, but also our willingness to sacrifice in order to save a fellow Soldier’s life.”⁶⁵

These words and phrases could serve to aid in identity fusion with one’s ingroup and the creation of a particular worldview. The full text of the Combat Medic Creed states:

My task is to provide to the utmost limits of my capability the best possible care to those in need of my aid and assistance.
To this end I will aid all those who are needful, paying no heed to my own desires and wants; treating friend, foe and stranger alike, placing their needs above my own.
To no man will I cause or permit harm to befall, nor will I refuse aid to any who seek it.
I will willingly share my knowledge and skills with all those who seek it.

⁶² Raffield, “Ingroup identification, identity fusion and the formation of Viking war bands,” 42.

⁶³ *Ibid.*, 37.

⁶⁴ “Oath of Enlistment,” Army.mil, accessed May 11, 2016. <https://www.army.mil/values/oath.html>.

⁶⁵ Fansler and Peters, *Not on My Watch*, xiii.

I seek neither reward nor honor for my efforts for the satisfaction of accomplishment is sufficient.

These obligations I willingly and freely take upon myself in the tradition of those that have come before me.

...These things we do so that others may live.

The Creed is an example of what a medic is to live by, and it teaches that a combat medic's metric for determining whether or not she has fulfilled her responsibility and lived up to her identity is based on what she does – for example, her ability to accomplish the “things” that are referenced in the aforementioned creed. When the responsibilities implied by either side of the creed go unfulfilled, when the medic is prevented from action (“these things we do”) or when the patient dies (“so that others may live”), the result could be an experience of uselessness, the antithesis of fulfilling responsibility. Robert Shippen remembers how it traumatized him when he found himself amidst countless bodies of American soldiers whose lives had not been saved:

There were just dead Marines everywhere...Freckle-faced kids to hardened NCOs, all dead...my reaction to those bodies and the mass casualty was, like I said, I went straight to God, not necessarily in a nice way. It was kind of like, “My God, how can you allow this?” I'm blaming God for all this stuff, which I was part of just as much as anybody else was. But I'd kind of been trained. I thought in my training that being a medic that I'm going to see a lot of casualties. That's what medics do. They're at the funnel end. There's a lot of destruction. In fact, the most horrible things that humans can even do to one another are done in a war. Medics get, they have to deal with it all... *I felt that I just wanted to do something. I was helpless. You're helpless when somebody's dead. You can't bring them back to life. When somebody's hurt, if you can do something, you do. You're not helpless because you're actually able to do something. When somebody's dead, there's nothing you can do except pray for them if you even pray...* I was just like overwhelmed by the death of these guys.⁶⁶

This experience was morally traumatizing for Shippen. He found himself feeling helpless at the sight of so much death, even though he admits that he was trained to expect the sight of casualties. As a medic he was conditioned to deal with injuries in those cases where he could “do something” to take an active role in saving a life, but the helplessness that he felt when there was

⁶⁶ Robert Shippen, Oral History Interview, Texas Tech University, my emphasis.

nothing he could do overwhelmed him. A medic's professional identity is grounded on performing in an active, healing role, and oral histories as well as medic memoirs indicate that a medic's failure to act and to be successful in that action could lead to morally anguishing situations. Shippen's statement displays that traumatic uselessness could lead to profound guilt linked to the medic's inability to do his job.

All of this can be summarized by saying that most medics enter a combat situation with some sense of what they are to aspire to, and this has been supported by the medics quoted in this thesis. When they step out on patrol, they know what they are expected to do if their skills are called for.⁶⁷ The chances of them saving every patient every time may be slim, and they may know that as well,⁶⁸ but their training has taught them that their primary responsibility is to save the lives of those with whom they serve.⁶⁹ Therefore, if a life is lost on her watch, the medic may have to learn to live with guilt and shame for the rest of her life.⁷⁰

4.4 Resulting Moral Trauma

What drives us is instinctive; it's innate, it isn't a choice. It's what we do because it's who we are. It's visceral. We have as little choice in being that man as we do in the color of our skin. Nothing in the world hurts like losing one of yours but we carry that so we can do what needs to be done.⁷¹

The medic quoted here has a conception of the relationship between his job and his identity, and he recognizes the anguish that results when a patient is lost. The importance of rhetoric – such as creed and motto – in military training has already been established, as has the impact of such rhetoric on identity formation. From this, it can be surmised that combat medics develop a firm understanding of “what's right,” and that this understanding is heavily reliant on the actions and

⁶⁷ Robert Shippen, 12.

⁶⁸ Fisher and Jenkins, “Ranger Medic: Drive for Perfection.”

⁶⁹ John Hubenthal, 7.

⁷⁰ Hunter Hayes, 15.

⁷¹ Fisher and Jenkins, “Ranger Medic: Drive for Perfection.”

abilities of the medics themselves. These elements provide ample opportunities for medics to experience moral trauma if their ideas of “what’s right” are betrayed.

The combined impact of the way that these individuals are trained, the nature of their roles, the link between professional and personal identity, ingroup identity formation and identity fusion, and the feelings of uselessness that they may experience can all be understood helpfully through the lens of moral injury. Medics are taught who they are supposed to be and what standard they are supposed to live up to, and inevitably they fail. At least for some combat medics, this goes beyond a simple sense of professional failure to the extent that it fundamentally upsets their sense of reality and the way that is supposed to be. This is where moral injury may result.

As was previously mentioned, combat medics occupy an inherently active role where success or failure often determines whether or not someone lives, and it depends almost exclusively on the things that medics do or do not do. In the interviews for this project, medic veterans described some of their most anguishing experiences in language of their being “useless” or “helpless.” I argue that the medics spoke in these terms to describe their most traumatic experiences because they are the opposite of the life-saving agency that medics are trained to perform, and therefore represent the antithesis of the medics’ identity and a failure to fulfill their purpose. This was supported by Robert Shippen above when he was quoted saying:

I was helpless. You’re helpless when somebody’s dead. You can’t bring them back to life. When somebody’s hurt, if you can do something, you do. You’re not helpless because you’re actually able to do something. When somebody’s dead, there’s nothing you can do except pray for them if you even pray...I was just, like, overwhelmed by the death of these guys.⁷²

Stephen Presser expressed a similar sentiment:

That was the most traumatic experience I remember, even when I was being shot at before or afterwards, it didn't hit me like that one did. I began to tremble, my teeth were

⁷² Robert Shippen, Oral History Interview, Texas Tech University.

chattering, and I couldn't stop it. I was completely useless. And I was praying to God that no one would holler "medic," because I didn't know what I could do...I've never been that frightened before, and I hope I'm never that frightened again...It was overwhelming, I was just overwhelmed."⁷³

There is a unique sense of responsibility that the medic culture is designed to create.

Whether or not medics become friends with the people they care for, there is an intense connection with their fellow unit members because of the bonds of ingroup formation and identity fusion. All of this sets the medic up for a specific kind of moral experience because his professional identity has become indistinguishable from the responsibility they have to provide care to this particular ingroup. When they are unable to save a patient, their bond with the ingroup makes them less likely to have the protective distance of objectivity. These are situations where the medic's professional role cannot be separated from his sense of identity. This can lead to an exaggerated sense of moral responsibility tied to their professional role, which makes this population vulnerable to morally traumatic experiences.

5 MORAL INJURY

Dr. Rita Nakashima Brock argues that moral injury is a form of psychological trauma that occurs when individuals "violate their core moral beliefs, and in evaluating their behavior negatively, they feel they no longer live in a reliable, meaningful world and can no longer be regarded as decent human beings."⁷⁴ Symptoms of moral injury can be similar to those of post-traumatic stress disorder (intrusions, avoidance, numbing), but can also be distinct and recognizable (shame, guilt, demoralization),⁷⁵ and the contexts under which moral injury will

⁷³ Stephen Presser, Oral History Interview, Atlanta History Center.

⁷⁴ Brock, *Soul Repair*, xv.

⁷⁵ Shira Maguen and Brett Litz, "Moral Injury in Veterans of War," *PTSD Research Quarterly* 23(1):1, 2012.

arise have defining characteristics that can be distinguished from those where an individual may develop PTSD.

There are many different definitions of moral injury out there. For the purposes of this paper, I have focused on the work done by Dr. Jonathan Shay, Dr. Brett Litz, and Dr. Rita Nakashima Brock, as these are the most influential scholars working in the area right now. In his groundbreaking book *Achilles in Vietnam* (1995), Shay uses the term *themis* to refer to “moral order, convention, normative expectations, ethics, and commonly understood social values.”⁷⁶ Put more simply, *themis* is what’s right. The betrayal of what’s right is unlike other forms of psychological trauma – it is a deeply-felt disruption of one’s understanding of the world and one’s place in it. It can uproot an individual’s entire identity and make returning to “normal life” impossible.

Shay has worked as a medical doctor and clinical psychiatrist at the Department of Veterans Affairs for nearly thirty years, treating Vietnam combat veterans. His research seeks to encourage a better understanding of veterans, and his time as a psychiatrist led him to believe that treating PTSD alone does not get to the root of the problems his patients were experiencing. He takes seriously veterans’ feelings of guilt and shame, and he came to the conclusion that something further must be done to address these feelings. In this pursuit, he developed the concept of “moral injury,” which he presented as stemming from circumstances where: (1) there has been a betrayal of what is morally correct (2) by someone who holds legitimate authority (3) in a high-stakes situation.⁷⁷

Fifteen years after Shay published *Achilles in Vietnam*, a team of researchers led by Dr. Brett Litz expanded Shay’s concept of moral injury. Litz defined moral injury as resulting from

⁷⁶ Shay, *Achilles in Vietnam*, 5.

⁷⁷ Ibid.

situations of “perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.”⁷⁸ This broadened definition recognized that an *individual* could commit a transgression that would result in moral injury, rather than the betrayal always taking place at the level of a superior, as Shay had previously suggested.

Three years after Litz’s publication, Brock and Lettini added a spiritual dimension to definitions of moral injury by describing those who experience it as having “souls in anguish,”⁷⁹ as opposed to any suffering being purely psychological. Brock would argue that PTSD is distinct from moral injury, and *Soul Repair* (2012) sought to clarify this distinction. Brock and Lettini expanded the vocabulary of moral injury to be more spiritual, rather than strictly moral. Though the degree to which they achieved their goal of sharpening the definition of moral injury is debatable, they did manage to open the door for the faith community to participate in the reintegration of veterans.

A definition that displays how understandings of moral injury have evolved from earlier concepts is presented in a concept validity study published in 2011 by a team of researchers led by Dr. Kent D. Drescher. They describe moral injury as:

Disruption in an individual’s confidence and expectations about one’s own or others’ motivation or capacity to behave in a just and ethical manner. This injury is brought about by bearing witness to perceived immoral acts, failure to stop such actions, or perpetration of immoral acts, in particular actions that are inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others.⁸⁰

This study goes on to ask, “can moral and ethical violations be uniquely and lastingly injurious to war veterans? Although systematic research on the bio-psycho-social-spiritual impact of

⁷⁸ Brett T. Litz, Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P. Nash, Caroline Silva, Shira Maguen, “Moral injury and moral repair in war veterans: A preliminary model and intervention strategy,” *Clinical Psychology Review*, 29: 697, 2009.

⁷⁹ Brock, *Soul Repair*, 51.

⁸⁰ Kent D. Drescher, et al., “An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans,” *Traumatology* 17(1): 9, 2011.

inflicting injury and death has been lacking to date, there is some evidence that this is the case.”⁸¹ This thesis argues further that there are moral and ethical violations which can be uniquely and lastingly injurious and do not involve inflicting or suffering injury and death, as earlier definitions have suggested. The medic's responsibility to protect or save the lives of those around her is both a professional and a moral responsibility. When the medic fails to fulfill this responsibility, it can cause a moral violation that is uniquely and lastingly injurious.

Taking the genealogy of moral injury into account, the working definition of moral injury that is used in this thesis is: an intense inner conflict characterized by profound guilt and shame that arises as a result of a severe betrayal of what's right and that interferes with normal functioning in everyday life. This disruption can occur by perpetrating, failing to prevent, or bearing witness to trauma that is associated with a sense of personal failure and a loss of understanding about one's morality, as well as one's meaning and purpose in the world. The concluding elements of this description, referring to personal failure, represent the contribution that this thesis suggests to our growing understanding of moral injury.

As was mentioned above, moral injury and post-traumatic stress disorder are not interchangeable, though there may be some overlap between the two. In order for an individual's symptoms to be classified as moral injury, her trauma must have had some element of betrayal or transgression, though this can manifest in many different forms. A person who witnesses or undergoes a traumatic experience, whether in a combat zone or in a car accident, *may* find themselves experiencing stress reactions that will not resolve without treatment, and this is PTSD.⁸² Moral injury has different qualities: “When we feel that we what we did was wrong or

⁸¹ Ibid., 9.

⁸² “What is PTSD?,” US Department of Veterans Affairs, n.d., accessed May 23, 2016. <http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp>.

unforgivable and that our lives and our meaning system no longer make sense, our reason for living is in tatters. This shattering of the soul challenges what holds life together, and the anguish of moral injury begins.”⁸³ Though, of course, not every person who experiences trauma will find themselves suffering from PTSD or moral injury, these are examples of situations in which these may arise.

The oral histories I reviewed for this project suggest that the inability to fulfill a strong sense of responsibility could cause moral trauma. On one occasion, Shippen switched duty assignments with another medic who had gotten drunk. Shippen took the more precarious task of going out on patrol, and allowed the other medic to stay in camp. However, while he was away, the other medic mishandled a mine and was killed. Shippen describes the incident:

I felt responsible in many ways, my own guilt about it because if I had just left it alone and not tried to fix it or make it better, he could've just ridden down on the back of a truck...I would've been the one who had been putting in the Bouncing Bettys [mines] and I would've been straight and squared away and nothing would've happened, just a routine day.⁸⁴

In this case, though his intentions may have been good, his actions led to the death of a comrade. He describes this event in terms of responsibility and guilt, which can be indicators of moral injury, though it cannot be determined from this quote alone whether or not Shippen's guilt was debilitating to the extent of moral injury.

A combat medic may find herself in a position to experience moral injury if she is not able to save a patient, since she has been trained to identify personally with her occupation, and her understanding of professional success or failure has been tied directly to her responsibility of saving the lives of injured soldiers. When an individual is taught that her moral purpose is to save the lives of those around her, as combat medics are, the loss of a patient may cause enough

⁸³ Brock, *Soul Repair*, 52.

⁸⁴ John Hubenthal, Oral History Interview, Texas Tech University.

guilt and anguish to cause moral trauma. The lens of moral injury research can be useful in interpreting these experiences. It is not always possible to determine whether or not a medic has actually experienced the *injury* of moral injury. However, it is possible to listen carefully to the veterans' language for key indicators of guilt, shame, and demoralization, though these words themselves may not be used. This methodology could prove to be insightful as the basis for a new way of approaching the treatment of returning veterans.

The construct validity article by Drescher et al. explains that treatments which may be appropriate for someone suffering from PTSD are not always appropriate for someone suffering a moral injury.⁸⁵ If caretakers want to be able to provide appropriate care to returning veterans with psychological traumas, they need to ensure that the veterans receive the proper diagnosis. This thesis attempts to point out that moral injury definitions, as they currently stand, may not allow providers to recognize injuries that are expressed in nontraditional ways. Specifically, the medics in the interviews presented here were more likely to express themselves in terms of uselessness and professional failure, rather than using the traditional moral injury language of guilt, shame, and demoralization. It is important to consider the context in which the patient's injury occurred, including the elements which created her moral world, in order to properly understand the injury itself. For combat medics in particular, using moral injury research in this way offers a useful lens with which to examine the medics' unique experiences of trauma.

5 CONCLUSION

Part of what is different about combat medics, as opposed to military doctors or nurses, is that they are embedded into units. As a result, the caregiver-patient relationships are not the same

⁸⁵ Drescher, et al., "An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans," 9.

as those between other military healthcare providers and their patients. Traditional healthcare providers come into contact with patients, who are usually relative strangers, treat them, and then let them go. In a combat context, the patient is somebody who the medic has been connected to through the identity fusion that occurs in an ingroup, even if he has decided consciously not to befriend that person.

The impact of this is that the loss of a patient for a combat medic can become a moral experience. When a medic comes to the aid of a wounded soldier, the wounded is often not anonymous. There is a bond between the patient and the medic and a decreased level of objectivity. When placed in a high-stakes scenario such as active combat, amid a group of soldiers with whom the medic has developed the bond of an ingroup, what may have started out as a relatively dispassionate career choice can become a moral identity. When wounded soldiers die on the battlefield, the medic may suffer intense moral anguish, as he has been unable to fulfill his professional purpose, and this violates his sense of self. These medics have figured out different ways to deal with this. Sometimes they just say, "I'm not going to treat another patient" and they walk away. Sometimes they say, "I'm just not going to make friends," but they often still feel responsible for the lives around them. This thesis has shown that, when a patient dies it becomes not a question of not supporting a friend, but rather a question of "I didn't fulfill my responsibility to these men."

For combat medics, whether or not this moral trauma leads to what we would classify as injury or not, there is a moral dimension to the experiences of medics. The interviews reviewed here present combat medics who are willing to talk about this moral dimension of their experience, and we can get a sense of what injury looks like from studying PTSD. From the research that was conducted for this thesis, what I can confidently suggest is how moral injury

may be expressed among combat medics. This population is likely to personally identify with a large burden of very specific responsibility to those around them. When this responsibility is betrayed, the medics often express their guilt in terms of professional failure (e.g. “I didn’t do my job”). For someone whose vocation has become tied to a moral identity, professional failure *can* mean moral injury.

As was stated above, Shay explains that moral injury can arise in situations where a trust has been betrayed by an authority figure, and Litz expands this understanding by stressing situations where an individual has “witnessed, perpetrated, or failed to prevent”⁸⁶ an atrocity. From the naturally limited data set that oral histories provide, it would be difficult to prove that the individuals quoted in this thesis have experienced moral injury. What is apparent is that the conditions that they describe are the conditions under which moral injury could arise, according to the experts. These are also the conditions under which moral injury would occur based upon my own definition. If that is the case, then perhaps it follows that caretakers should respond to people who have gone through experiences such as those described by the medics in this thesis as if they are at risk for moral injury, and not PTSD alone.

This is when the humanities at large, and oral histories specifically, have something distinctive to contribute to this conversation. Oral histories are constructed life stories - they are the recorded evidence of how an individual has come to express his experiences. Obviously oral history archives could not be used to diagnose someone with a condition, but what can be accomplished is the identification of recurrent narrative themes. If these themes resonate with indicators of moral injury, such as guilt, shame, and uselessness, then they may also serve as indicators of potentially unaddressed moral trauma. Paying careful attention to the ways that

⁸⁶ Litz, “Moral injury and moral repair in war veterans,” 697.

individuals tell their stories could provide a new avenue for understanding moral trauma and moral injury.

Apart from the military and medical implications of this, from an oral history research perspective, there are some problems worth addressing in future studies. In conducting interviews, veteran or civilian interviewers need to be aware of the distinct ways that different populations will use language. If particular care is paid to certain key terms and phrases, it may open the door to conversations that are often lacking in oral history interviews, particularly those regarding experiences of trauma. A more exhaustive analysis of the merits and shortcomings of the various oral history archives referenced here could be made, but would go beyond the scope of this thesis.

This thesis has laid the groundwork for additional interesting avenues for further research, such as the idea that perhaps not all moral injury is alike. Medics are unique because it is actually expected of them that they will act to save lives. Another soldier in the same unit may have the same bond to the group and may feel responsible for those around him, but only the medic has been told in his job description that "these lives are in your hands." This is a distinct and direct type of responsibility, and it carries with it discrete opportunities for moral injury.

We have been able to distinguish moral injury from PTSD; perhaps now additional scholarship needs to be conducted to distinguish certain kinds of moral injury from other kinds of moral injury. It might be useful to think about moral injury as a broad category to understand the depths of the experience that some medics are going through when they are not able to fulfill their responsibilities. This also makes for an interesting way to think about moral injury further, because it is a specific expression of moral injury that is different from what other soldiers

experience. Additional research into cases such as these will likely yield evidence that can expand our understanding of moral injury, and improve the care and treatment of veterans.

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APPENDIX

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