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Mixed Agency: a Historical & Ethical Examination of the Health Professional's Role in the U.S. Military Medical System

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MIXED AGENCY: A Historical & Ethical Examination of the Health Professional's Role in the U.S. Military Medical System

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Preface: Beginning in a Love Letter

The Postponed Letter

I ought to write a letter,
But I can't get into the groove.
If I could write some certain things,
You'd see my precise move.

I'd like to tell what town I'm in,
And just what things I do.
But must he content to wait until,
These wartime days are through.

I ought to write a letter,
And repeat the things you know.
The things they would not censor out,
Like how I love you so.

In 1945, my grandmother (portrayed above) opened up this poem for the first time. The author, Harold Victor Hassebrock (portrayed above), was lying in a hospital bed somewhere between the United States and Normandy, France. As I remember him, my grandpa had no penchant for words. I remember a gruff and tough old man, with shrapnel injuries that made his legs painful in life. My father will confess much the same; as the youngest of seven children (five boys and two girls) he remembers his dad as stern, proud, and loving, but not the type to write poems. After all, an eighth grade education does not lend itself particularly well to poetry. Yet there is a power to his onetime poem that hints at an experience so profound, it beckoned for further attention.

It is partially this exploration that I intended to take up with this thesis. You see, Grandpa seldom said anything about his experience in World War II, and when he did it was simply to say, "I hope you boys never have to go to war." I'm grateful he was able to handle what he went through, and yet at the same time many of us family members yearned to learn more. It is a part of our history, and one that we cannot simply learn to live without. Grandpa came back from the war and devoted his life to raising a God-fearing family. In so many ways we are blessed, and it felt right to return to the roots of what is possibly the most influential set of events in Grandpa Harold's life, WWII.

I guess I always knew that I'd run into this past at some point, and it was only natural to write a thesis that expanded on my own history. Socrates begs us to answer the question in *Phaedrus*, "where are you going and where have you come from?" As the first person in my family to attend medical school in the hopes of becoming a physician, this is my attempt at answering both. Where I'm going, where I come from, how God is present in my family's past and present, could all be explored through Grandpa Harold's eyes.

My grandfather wrote a series of letters to my grandmother over his time spent as a soldier. Most of these came in the form of a hospital pastime as he recovered from the operations he underwent on his legs. The two remained in close correspondence (sometimes receiving/writing four letters a day) as Grandpa was moved from one hospital to another, and treated in one way or the next. These letters were not discovered until my Grandma Ruth passed, and since then my family has preserved these love story treasures. It was reading through these letters

that I caught a commonly repeated theme. The more I looked, the more apparent it became that Grandpa was woefully unaware of the low standard of care often provided to him throughout his many hospital stays.

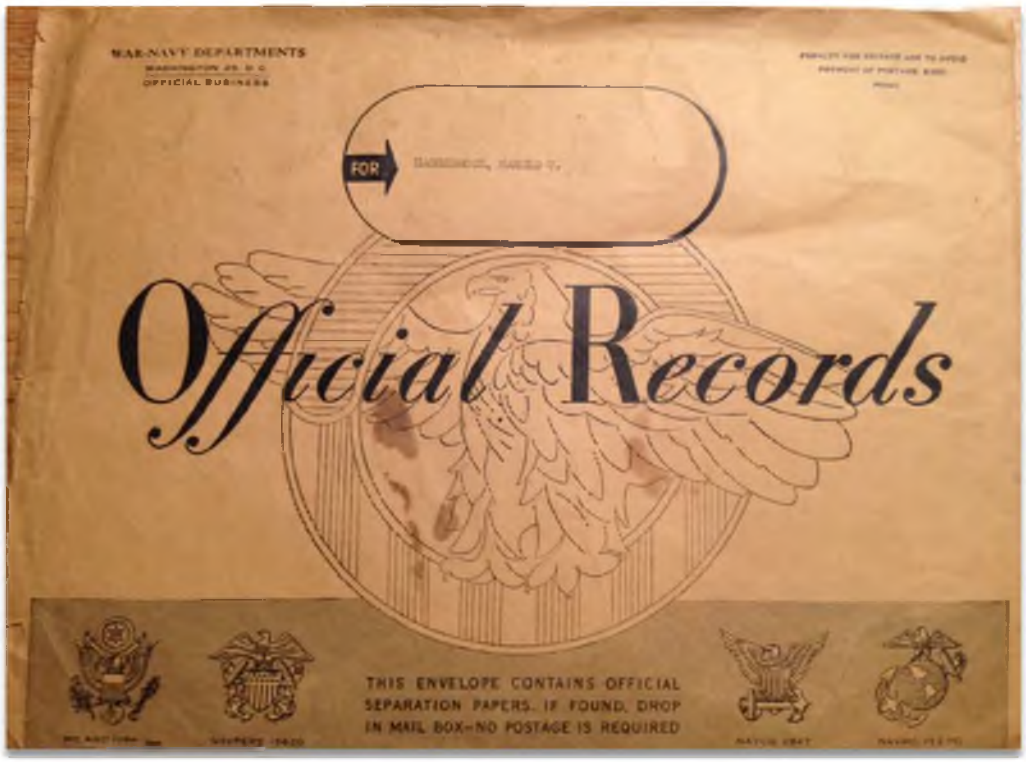
As an aspiring physician I have been exposed to the medical world. I know what is taught concerning patient's rights, and my classroom learning has been both validated and challenged in the real world while shadowing physicians in their daily tasks. That is why as I read these letters I grew alarmed at the signs I began to see. I saw in my grandfather not the informed patient, but rather the intentionally kept ignorant "vet." In a more concrete sense, the more I read, the more injustice I felt. It seemed to me that my grandfather had little to no idea what was going on with him, who was responsible for him, or what had been decided on his account. Additionally he had been moved so many times it was a constant struggle to even receive his mail, often writing letters that began in question, "Hoping the hospital has your reply my honey, for I haven't received it yet."

Many of us have experienced this disconnect in hospitals when frantic families meet the bureaucratic health care system, and yet it seemed enhanced in my grandfather's circumstance. This was a young man who had been asked by his country to sacrifice his life and future, had done so willingly, and was now being pawned around in a time of desperate need. With the added luxury of hindsight, anger grew inside me knowing that my grandfather would struggle the rest of his life and live in pain to his dying days with his injuries. I couldn't help but focus on these silent signs as I continued to read, and question how many more were affected in a similar way.

Now, eventually things turned out all right. Grandpa made it home and married my grandma in a double ceremony with his brother George and my Grandma's sister Lydia. Harold learned to walk with his legs the way they were, despite what the doctors said, and continued to live an incredible life. However, this didn't change the way I felt about his story; the problem of his care was *worth* exploring. How did he come to be treated in this way, moved around from place to place, and unable to recall who his doctor was? What system did the military use for our wounded veterans, were did it come from, and had it changed since Grandpa's experience? All these questions swirled around and founded the roots of this thesis.

The question of military care, and of military physicians, is an exploration of my past, and an inquiry into my future purpose. I began this process trying to sort out the system within which my grandfather lived, and ended trying to answer the relevant question of my thesis: "In an imperfect world what should military medicine look like?"

Chapter I: Bureaucracy and the Medical System—An Introduction



The United States has been in a relative state of constant engagement militarily since its inception in 1776. With the kickoff of the revolutionary war, the US has been in an ongoing battle to maintain safety and liberty for its citizens. Through two world wars, several foreign engagements, and a cold war, the United States' military has faced a wide variety of tests. Throughout this convoluted history, our military medical resources have also been heavily taxed. In World War I, systems were established for our soldiers who had been wounded in the line of duty. World War II demanded that medical infrastructure standardize and become regimented in order to handle the sheer numbers needing medical attention—My grandfather's records (shown above) emphasize this push to standardization.

Additionally wars like the Vietnam War or the Korean War required that medics become self-sufficient soldiers as well as medical personnel. Each new challenge brought with it a special set of demands that eventually shaped the low cost-of-life policies now implicit in our military system.

But what are those lowest cost-of-life policies, and how did they come to fruition? Along this bloody journey, millions of young men and women have been injured or killed in service to this country. Policies were set that regulate how those wounded and dying are treated, in what order they receive care, and even whether or not they are recovered. This practice, called "triaging" a situation, is an old one, however the crossover from standard operating procedure to institutionalized policy carries with it the baggage of some ethical decisions, known or not. Who decides the priorities? On what basis are military medical decisions made, first for the soldier and then the mission, or are they reversed? This thesis will seek to examine the development of these institutionalized policies and the contingency of battlefield situations by looking at situations where the young men and women of this country were otherwise circumstantially allowed to die. Additionally the dual ethical obligations of the individual physician-soldier will be examined, and the efficacy of this duality assessed. All too often this entrenched system fails to allow flexibility for its constituents, and these instances of failure, whether isolated or systemic, have the ability to illuminate the system at large.

U.S. Army specialist Chazray Clark is an unfortunate example of the veracity of this claim. In September of 2011, Specialist Clark and his company were the victims of a roadside Improvised Explosive Device (I.E.D.) explosion while serving in

Kandahar, Afghanistan.[1] Immediately immobilized due to the severity of his injuries, Specialist Clark's company began to tourniquet off his injured extremities and call in for a MEDVAC (military aid helicopter).[2] At this point it became clear to Specialist Clark's crew that although his body armor had prevented him from taking lethal shrapnel to the thoracic cavity, his wounds were still so severe that if he was not transported immediately he would lose his life. All this information was relayed to base camp where the MEDVAC helicopter would dispatch from to transport Specialist Clark to a nearby hospital. Assuming no extenuating circumstances, Specialist Clark would be picked up and delivered to an urgent care field facility for "Class A" injured soldiers in about twelve minutes.

Shortly after receiving the "MEDVAC needed" call at the base, the army MEDVAC team and helicopter were grounded due to a complex assortment of longstanding military regulations developed out of the Standard Operating Procedures (SOPs).[3] This delay ultimately caused the recovery and drop off of Specialist Clark to expand from an estimated 12 minute route to a 59 minute route. The Army has a self-imposed regulatory time scale for Class A injuries. Class A injuries have a 60-minute deadline from reported injury to drop-off at an urgent care facility. Now, while Specialist Clark's recovery was within Army regulations, he ultimately died in transit due to a lack of care caused by the delay.

How did this happen and what were the obligations that kept Specialist Clark's MEDVAC team grounded? It begins with the protocol surrounding MEDVAC

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[1] Yon, "13 Military Pilots Rebuke Joint Chiefs of Staff."
[2] Yon, "13 Military Pilots Rebuke Joint Chiefs of Staff."
[3] Yon, "13 Military Pilots Rebuke Joint Chiefs of Staff."

unit, and the larger military itself. MEDVAC helicopters are painted with the Red Cross symbol and are outfitted exclusively for transport capabilities. They carry a light payload of weapons, nothing more than personal firearms on their core men, and contain three beds for in route treatment of the injured soldiers. By Geneva Code definitions, they are an unarmed aircraft and their Red Cross insignia reflects that. The problem that arises with this classification is that the army's standing protocol for MEDVACs, or unarmed aircrafts, is that they cannot enter an active "hot zone" without an armed escort. Unfortunately Specialist Clark was in a "hot zone", and his MEDVAC was grounded due to this classification and the lack of a free escort helicopter to accompany the team. Specialist Clark's care providers were encountering the fallout of a system developed by trial and error around centered protocols. The way the army's care system developed leaves no room for physicians to accommodate to the contingency of a situation. Instead, the MEDVAC team was grounded until a neighboring Apache attack helicopter could be freed up to accompany the rescue team. The combination of the "Red Cross" designation of the MEDVAC team, the existing structural limitations upon this unarmed designation, and the classification of Specialist Clark's area as a "hot zone" all combined to result in a delayed rescue attempt. Specialist Clark's situation was complex, and therefore even though there weren't extenuating circumstances, Specialist Clark's situation took a dire turn.

These outcomes are incredibly rare for our armed forces. In fact, the only reason that this particular incident was so well publicized was the presence of an independent reporter with the Army Specialists team. The army reports that of all

evacuation/medical rescue missions it received this last year of combat, a small minority of "Class A" injuries arrived late to their respective care facilities. Additionally the numbers imply some clear truths. The war in Afghanistan and the war in Iraq combine to give the Army just an 8% casualty of war statistic (a statistic that represents the percentage of those deployed who were fatally wounded).[4] This puts the Army, statistically, into the best care position they have ever been in throughout all the major conflicts, Revolutionary War forward. The question then becomes whether or not it is justifiable to continue such policies. Are these policies and institutions ethically sound if by the death of roughly 8% of active duty personnel, they are able to sustain the highest rate of survival in the history of the Army? Do healthcare providers have a higher ethical responsibility to uphold the *telos* of the army's utility-focused system, or do they have the higher calling to sustain the lives of the service men and women they swore to protect as medical providers?

The existence of the dilemma resides in the scarcity of available army physicians, and the ensuing arguments over how best to ration medical attention. When one medic is responsible for support of a troop 400-800 men strong, some scarcity will necessarily ensue.[5] The Army's primary philosophy when it comes to medical treatment in answer to this scarcity is utilitarian,

> *Some with the greatest need are beyond saving. Others with great need can be saved, but doing so will require extraordinary resources. In order to save them,*

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[4] Edgar, "Baghdad ER," 1-11.
[5] Berger, "Lessons from Afghanistan," 486-488.

*many other lesser injuries will have to be abandoned. Utilitarian's (*often army personnel*) observe that in some cases, more good can be done in aggregate by targeting those with lesser injuries.*[6]

This matches the actions taken by the MEDVAC unit and the decisions by superior commanders in the case of Specialist Clark. Despite the circumstances of one man, at the margin, these policies increase the overall aggregate good provided to the servicemen (in this case healthcare). When faced with the drastically increased demand for medical treatment that a war creates, combined with the simple fact that a "limited number of available health care professionals cannot adequately respond to all demands at the same time," the utility of these instituted policies begin to seem well founded.[7] A soldier who is operating under this utilitarian mindset also has mental view of the operational effectiveness of the mission.[8] Therefore the overall efficacy of the mission is contemplated as part of the aggregate good in reference to any possible medical actions.

This sort of focus on the utility of military healthcare lead to the implementation of a specific kind of care—the triage system—which was then widely developed by the United States Military due to its efficiency and respect for chain of command. This triage system, first described by two eighteenth century British physicians, focused specifically around dealing with the large numbers of patients. This was partially motivated by dealing with the disease pandemics of the

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[6] Veatch, "Disaster Preparedness," 236-241.
[7] Ibid., 236-241.
[8] Kelly, "Battlefield Conditions," 636-645.

time, like the typhoid pandemic.[9] This triage system utilized many classifications, but the brunt of the manpower was devoted to the first—primary importance—and second classes. With the overall goal of the practice of medicine being improving mortality and morbidity statistics, the group with the highest ability to do so is the "lesser injuries" group. Many physicians of the time, and even today, operate their emergency rooms under a similar principle. In a military setting, the benefits are even more obvious. To focus on the aggregate ability for servicemen to become "fit for combat" is the primary motivation for healthcare in a military setting, and indeed the paraphrased motto of the Army's medical branch.[10]

Despite the effectiveness of such a policy in maintaining a high survival rate during military engagements, problems abound with this type of ethical reasoning. Not the least of these problems is the loyalty conflict that this sort of ethical reasoning places medics in, what I will refer to as "mixed agency". This stems from the physician's (or simply the medical personnel's) ethical conduct derived from the Hippocratic oath that reads as follows:

> *The ethic of the oath, at least as it has been interpreted in modern medical ethics, is simple: the physician's sole duty is to promote the welfare of the patient and to protect the patient from harm.*[11]

This implies that the medical personnel in an army are torn between two conflicting loyalties. The loyalty one feels towards duty, the utilitarian aggregate good, and the

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[9] Veatch, "Disaster Preparedness," 236-241.
[10] Kelly, "Battlefield Conditions," 636-645.
[11] Veatch, "Disaster Preparedness," 236-241

loyalty one feels towards the patient per the "principle of justice,"—hence the term 'mixed agency.'[12] If military medics were to adhere to this principle strictly, then there would be no question as to what Specialist Clark's MEDVAC crew would have done. The crew members would have defied their cease fly orders and immediately gone to recover the wounded man with or without gunship assistance. Occasionally, the Hippocratic oath is distorted by simply transferring the subject of the oath from the individual to the community at large. While this shift may cause the physician to become more comfortable with utilitarian triage, it is nonetheless a distortion of the original Hippocratic oath's purpose. Doctors who truly "practice what they promise" would be incapable of making this sort of ethical shift and would therefore object to focusing on the aggregate good over the individual.

Why then would the military medic cease to uphold his Hippocratic oath in favor of the more utilitarian motivated orders to wait? The answer is that although the Hippocratic ethic involved in medical treatment of civilians is a possibility, upholding this ethic in the heat of battle is nigh impossible. The problem that arises stateside from a physician shortage is amplified tenfold in a wartime scenario. Field medics and physicians alike are forced to triage their situation into the three familiar primary classes with slight modification: "those with wounds so minor they do not need immediate attention, those who are critical and can receive significant benefit from immediate attention, and those beyond hope…"[13] This act in and of itself strains the Hippocratic ethic, a doctor cannot simultaneously triage the seriousness of the wounds of several patients and uphold the best interest of all the

[12] Ibid., 236-241.
[13] Ibid., 236-241.

patients. Scarcity in the military setting necessitates triage practices and therefore invalidates pure adherence to the Hippocratic oath.

Another common form of "triaging" emerges from this Hippocratic consideration of the duty a doctor has to his individual patients. Championed initially by Napoleon's surgeon general during the Napoleonic wars, this form of triage also recognizes the previously defined three categories, but chooses to appropriate medical attention differently. Instead of focusing primarily on the lesser injuries, which could be healed quickly and efficiently, medical resources were allocated on an urgency of need basis, excluding those that were beyond recovery. Expanded, the Napoleonic military medical system looked like this,

> *The hopelessly dying was left untreated on the battlefield. It made no sense to treat the worst off if it did no good whatsoever. Once that group was set aside, the ranking was based on severity of injury, not on efficiency in treating.*[14]

Under such a system, Specialist Clark would have been the perfect candidate to receive the brunt of the military resources. There would have been no waiting time for a gunship because Specialist Clark would have been the absolute primary target of the available resources, thus the "hot zone" would have been irrelevant. Despite the possible advantages of rescuing several other less-wounded soldiers, a "Class A" injury like Specialist Clark's would have received precedence. Under this ethical paradigm, the military MEDVAC team who failed to leave, as well as the command post that instituted the plan of action, would have been acting unethically. By not

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[14] Ibid., 236-241.

responding as quickly as possibly to Specialist Clark's situation, the MEDVAC team (and Army at large) failed to allocate their resources to the highest need, and the commanding officers failed to provide promised care for their enlisted man. However, as previously stated, our military believes first in maximizing efficiency, and substantiates this stance on the basis that adherence to a form of triage designed around the Hippocratic ethic is impractical in real world situations. Thus the U.S. military medical system takes a separate ethical stance from that of the Napoleonic institution of the late 18th century.

Although strict adherence to this Hippocratic ethical oath in the midst of battle is improbable, there is some good that comes out of its consideration. The Hippocratic ethic overall provides the combat medics with perspective with which they can assess the other policies they are asked to uphold. While the utilitarian ethical mindset calls for contemplation of the utility of actions, or the aggregate good, the Hippocratic ethic forces health professionals to see their patients as more than just commodities or cases, but rather as people. So where does this leave the combat medic? Did Specialist Clark's MEDVAC crew make the ethically sound choice? The answer to this question is still elusive; it continues to depend on what ethical system the medics *ought* to place themselves in, and concurrently what forms of "triage" they were performing. Perhaps, this is by its nature an unanswerable question. We cannot possibly know the ethical struggles that Specialist Clark's medics did or did not go through. What can be asserted though, is a framework for future trauma decisions that answers the question: what *should* an ethical system for military trauma look like?

In order to examine the validity of the current system, one must first understand the development of the current medical system, and the shaping influences that guided this system into its current state. In other words, in order to argue what *should be*, it is important to first know what *is*.

Chapter II: The History of Development

United States Military medicine predates the inception of the United States itself. April 30th, 1775, Andrew Craigie was appointed "Apothecary" of the Massachusetts Army[15], a term that is curiously unfamiliar to modern medical practices. At the time, his duties included, "providing beds, linen, and other supplies necessary for patient care," and shortly after the Continental Congress would go on to adopt such a position for its own use on the national scale.[16] The meager nature of medical science in the late 18th century limited revolutionary medicine. As the science of medicine progressed, military medical practices evolved both to meet the rising strains of conflict, and also in response to the innovations in medical theory and practice.[17]

The time period from the revolutionary war of 1776 until the civil war of the 1860s was largely stagnant in terms of military medical progress. The system, or lack of a system, was catered to the fighting style used largely to combat the British forces and then later for Indian wars. Thus the medical system evolved fighting two separate conflicts, developing as localized cells to fight the British, and then again as mobile units to fight the Indian mobile forces. However, problems existed under this system that foreshadowed the need for a national medical doctrine and standardized practice for the military. In 1809 Dr. William Upshaw denounced the current system whereby, "an unfortunate force of about two thousand soldiers was

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[15] Ginn, *The History of the US Army Medical Service Corps,* 3.
[16] Ibid., 3.
[17] Ibid., 4-5.

decimated by disease as it deployed to defend the newly acquired lower Mississippi territories."[18] This ineptitude in rationing care and supplies effectively persisted until the Civil War. In the face of changing weapon technologies like rifling, outdated war tactics increased the casualties of the Civil War substantially. This influx of wounded strained the existing satellite military medicine structures but the following response eventually produced some of the casualty evacuation and treatment doctrine that continues today.[19] This was not the only instance of development, but it was one of the beginning motivations for changing the existing medical structure.

The Civil war was the first large collision point that moved military medicine forward. Ineptitude was brought to the forefront, and focus rapidly shifted to include the military medical advances of the French and the English. Florence Nightingale made tremendous advances in basic hospital sanitation and saved countless lives in the fight against infection; and Napoleon's surgeon general (Baron Dominique Jean Larrey) perfected a system of rationing treatment dubbed the "flying ambulance" that reportedly treated every patient within a fifteen minute waiting time.[20] Advances such as these drew painful attention to the American field hospital system that could be located most often by, "piles of amputated limbs."[21] Public opinion began focusing on medical treatment, sanitation, and delegation of resources as the numbers of volunteer medical personnel increased. As questions arose among the populace about inadequacy and misuse of materials, the military

[18] Ibid., 5.
[19] Ibid., 9.
[20] Ibid., 6.
[21] Ibid., 9.

considered moving to define a set of protocols concerning conflict medicine. This led to the recognition of the need for a national "doctrine to unite people, equipment, and facilities into an integrated system of support."[22]

The first concerted step towards creating such a doctrine was undertaken by Brigadier General William A. Hammond who replaced General Finley in 1862 as surgeon general.[23] Hammond pushed for a bill of legislation that would address the way medical personnel evacuated the sick and wounded. At the time, medical evacuations were performed either by untrained hired wagon drivers, or combat soldiers pulled from duty. Those that were able to crawl often were captured while attempting to maneuver to help, while others were simply abandoned due to ineffectual evacuations. Commanders also noted during this time period that rarely did soldiers commandeered to aid in transporting the wounded ever return to the battle. Confederate and Union commanders alike bemoaned the negative utility of this evacuation system noting, "If any from the ranks are drawn from the fight to carry off the wounded, they never return until the fight is over, and thus three are lost to the company instead of one wounded."[24] Despite the obvious evidence that implementation of some sort of ambulance corps would be effectual, President Lincoln's Secretary of War Stanton responded that the presence of specified medical personnel for evacuations purposes may, "spread panic among the sliders who might view them as harbingers of suffering and death."[25] Hammond's legislation was turned down in the midst of such suspicions and it wasn't until Major Jonathan

[22] Ibid., 11.
[23] Ibid., 13.
[24] Ibid., 12.
[25] Ibid., 13.

Letterman implemented a similar system from bottom-up that the merits of such a system were fully recognized.

The "Letterman Plan" consisted of three primary goals: coordinate casualty evacuation, organize medical logistics, and establish field hospitals along evacuation chains.[26] The true test of such implementation came at the Battle of Antietam where up to 25% of soldiers who went into action were wounded; both armies' combined casualties totaled over 22,700 after just twelve hours of fighting.[27] On the Union side, under the Letterman plan, all casualties were effectively removed and treated that night. The Confederate side however, was not able to finish removing casualties until the following night.[28] Three months later, after commanders had the chance to observe the utility of a system that reduced straggling and saved the wounded, the Letterman plan was fully implemented.[29] Despite the immediate benefits to the wounded, only when the benefits of sparing combat soldiers from evacuation duty became recognizable did the Letterman Plan truly take hold. Soon after this implementation, medical evacuations personnel were assigned to their own units within the army, and given control over regulation of their own supplies such as wagons and equipment for transport. Effectively, the new protocol became separation of medical troops under their own structure and this led to greater efficiency overall. This move garnered praise from French Army surgeons who

[26] Ibid., 13.
[27] Ibid., 13-14.
[28] Ibid., 15.
[29] Ibid., 15.

recognized the efficacy of such a new system. In retrospect, the advantage this gave the Union over the South during the civil war was immense.[30]

The Confederates, however, also made some military medicine implementations worthy of note, mostly along administrative lines. As the Confederate army evolved from a small regular army to a large volunteer based force, the need for a class of officers who delegated logistical duties, and controlled medical supply lines became apparent.[31] The Confederate army, as a result of this implementation, enjoyed a far greater clarity of supply logistics, and therefore wasted far less resources. The Union later adopted such specialists, calling them U.S. Army Medical Storekeepers, and empowered them to manage and control medical supply lines within the emerging separate medical structure. This freed up physicians, who had been doing this work, to devote their time towards their actual profession.

With the increased specification and allocation of duties, the civil war helped to largely shape the future of the military medical corps. The improvements that had accrued during the civil war were due in part to advances in medical technology, but due in a larger part to the improvements in medical support.[32] As a whole, the medical system that emerged in response to the civil war was, "the largest, most complex, best integrated military medical system the United States

[30] Ibid., 16.
[31] Ibid., 16.
[32] Ibid., 19.

was to know until the twentieth century."[33] The system was so effective, that it wasn't until World War I that a more advanced system of care would be called for.

World War I ushered drastic changes in the way military medicine had to respond to the increased deadliness of war. Despite arriving as the latecomer to the European continental fighting, the U.S. would end up deploying 2 million soldiers and suffering 106,378 deaths before the restoration of peace.[34] The massive fatalities (though less than the Civil War), caused by an explosion in military technology, like artillery and chlorine gas, led to a staggering demand for military medicine amongst both the Allies and the Central-Powers. It is estimated that during 1916, British victory was coming at the price of 8,222 casualties per square mile of trench warfare.[35] To parallel, the U.S. itself experienced an increase from 444 physicians at the start of the war to over 31,530 near the conclusion to accommodate to this medical need.[36] This drastic U.S. increase was not only to support its own troops medically, but also due to the large medical support volunteers and later soldiers provided for our allies during the course of the war.

As killing outpaced medical technologies of the time, the Allied armies groped to find better ways to cope with the massive flux of dead and wounded. While medical technology was still without basic antibiotics and antibacterial sulfonamide drugs, some terrific peacetime planning allowed U.S. medical technology expediency to those with treatable maladies.[37] In many ways the WWI

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[33] Ibid., 19.
[34] Ibid., 37.
[35] Ibid., 37.
[36] Ibid., 37.
[37] Ibid., 38.

medical response was similar to that of the civil war: what we couldn't make up for in medical technology advances, we strove to make up with efficient evacuation and treatment times. This was largely aided by the ambulance service instituted in WWI.

The ambulance service came to fruition in the U.S. army similarly to the Letterman plan of the Civil War; it rose from the bottom up. As popular support for the war increased among the American people, volunteers enlisted in droves to support the effort of the Allies in France and Italy even before the U.S. was officially committed to the war.[38] The most prominent figure exemplifying this volunteerism was Ernest Hemingway, who volunteered as a second Lieutenant with the American Red Cross Ambulance Service and was later wounded while supporting the Allies in Italy.[39] While the benefits of having increased medical support, especially for evacuation purposes, were immediately apparent, what was less apparent were the long-term consequences of the ambulance volunteer agencies. "The volunteer ambulance units refined motorized evacuation techniques that were later adopted by the U.S. Army when it entered the war."[40] This refinement came to be incredibly useful. Companies knew which ambulance cars to use, how to drive them, what their limitations were, and how far a person could be transported whilst maximizing utility and care. Additionally, the benefits of enlisting specified personnel to transport the wounded again showed its utility as it did with the Letterman plan. To a larger degree, "… it was as illogical to expect doctors and surgeons to accomplish

[38] Ibid., 38.
[39] Ibid., 38.
[40] Ibid., 39.

this work (transport and evacuation) successfully as it would be to ask automobile experts to do surgical and medical work in the dressing stations and hospitals."[41] Ambulance crews showed their usefulness so convincingly that when the U.S. decided to become involved, they did so with the expectation that these individuals would either be commissioned to continue service, or else a force would have to be developed to take their place.

The Ambulance corps fit well within the larger scheme of military medicine preparedness that flourished after the lessons of the Civil War. The U.S. had learned to be prepared for massive expansion of active forces during wartime from its previous war experiences. Medical doctrine prior to WWI established an evacuation scheme with the primary goal being speed. Three zones were established: the zone of advance, the line of communications, and the service of the interior. With the establishment of this doctrine defining not only the organization of evacuation, but also the purpose behind the process (speed), the first triage implications began to arise. The American system adhered to a philosophy that stemmed from their organized echelons of care: the more serious the injuries, the further one had to go into the zones of care. For example, within the zone of advance existed Company aid posts→Battalion aid stations→dressing stations→ and finally field hospitals which were commonly located about eight miles from the front lines. All the while the purpose of these immediate medical outposts was not focused on definitive care, but rather stabilization, and further evacuation into the interior based upon triaged

[41] Ibid., 39-40.

severity.[42] Evacuation then moved into the second echelon, the lines of communications, and from there, if severity of the wound was high enough, across the Atlantic to general hospitals in the U.S.

The entire purpose of the system that emerged from doctrinal implementation during WWI was therefore speed and stability. "The AEF (American Expeditionary Forces) moved serious cases as quickly as possible to the rear after the patients had been appropriately stabilized for further movement."[43] This system that emerged, differed drastically from the French system. The French focused not on expediency, but rather placed a more sophisticated force further into the lines of combat for definitive care. These doctrinal differences resulted from lessons learned during previous wars. The U.S., with its necessitated mobility during previous wars, developed a system that relied upon rapid transport by independent non-physician medical personnel. Medical stabilization could be given in route and further transport provided based upon severity of the injury. The French 'Napoleonic' system was rather more immobile, but relied upon independent non-medical transporters to deliver patients a short distance for definitive medical care.[44] It was a conflict of care based upon a deeper level of conflict stemming from ethical ideas about performance. The American medical delivery system and the French System reflected different approaches to disseminating care; while the French focused on liberty and definitive care, the American experience led to a system of mobility and utility.

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[42] Ibid., 44.
[43] Ibid., 45.
[44] Ibid., 45.

These differences in doctrinal military medical practice, developed out of differing military experiences, combined to inform different directions for instituted medical evacuation systems. WWI was both a static trench war on the western front, as well as a war of mobility on the eastern front, so both systems demonstrated a utility. However, while the U.S. soldiers enjoyed the "best record yet for the medical support of an American army in the field,"[45] the systems that were implemented to provide that support were done so with the focus on efficiency and maximizing utility for the larger force.

In addition to maximizing utility on the evacuation front, WWI was also a time of systemic restructuring towards the same purpose of efficiency. By 1916, Surgeon General William C. Gorgas had testified before Congress on the need for specialization and relief in the medical forces. Again, "He noted the difficulty created by an insufficient number of military physicians and the burdening of that group with administrative (and specialized) responsibilities."[46] The plans of action from the Letterman plan found traction and prompted expansion under the growing demands of the First World War.

As the U.S. entered the war, general order No. 80, allowed General Gorgas to establish the administration for which he saw a need.[47] Operating under the name "Sanitary Corps," this corps contained a collection of individuals with, "specialized skills in sanitation, sanitary engineering, in bacteriology, or other sciences related to

[45] Ibid., 38.
[46] Ibid., 57.
[47] Ibid., 57.

sanitation and preventive medicine…"[48] These forces provided the labor behind the medical advancements of WWI, and allowed physicians to focus on treatment rather than maintenance of sanitation. As medical technology advanced to the point of recognizing animal and parasitic vectors (head lice, fleas, rats, ect.), the sanitary standards of England's Florence Nightingale took on new meaning and the Sanitary Corps became the U.S.' institutionalized response. Just as the Ambulance Corps changed the burden of transport from random soldiers to a specialized force, the Sanitary Corps shifted the burden of preventative measures from overwhelmed physicians to specially trained individuals.

As they took over preventative measures, the Sanitary Corps also evolved to meet the changing demands of the hospital structures foreign and domestic. "The twentieth century saw the hospital become the central institution in American Healthcare… Advances in medical technology propelled a dramatic expansion in the ability of such institutions to treat and cure their patients. At one time charitable institutions for strangers and the poor, hospitals became centers of community health…"[49] As civilian hospitals underwent this change, so did military hospitals. In fact, the growing reliance upon this new treatment ability of the hospital, combined with the Sanitary Corps' focus on preventative measures, resulted in the achievement of the first ever U.S. deaths-in-battle ratio of 1:1 (one death in the line of duty for every death due to disease).[50]

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[48] Ibid., 57.
[49] Ibid., 63.
[50] Ibid., 63.

Sanitary Corps members infiltrated every level of the medical department, assisting in everything from administrative duties to expanding specialized scientific inquiry. Preventative measures included "the establishment of water purification units and sewage treatment plants, construction of proper latrines and bathing facilities, removal of animal manure, regulation of kitchens and food preparation, fielding of rat extermination programs, and inspection farms and dairies…"[51] This, in conjunction with gas defense specialists, entomologists, x-ray technicians, physical rehabilitation officers, nutritionists, and other laboratory specialists, provided incredible preventative and rehabilitory medical power, and effects of this cannot be overstated.[52] For example, in 1915 fear of the Typhus epidemic prevented Austria from attacking Serbia for 6 months. In contrast, American forces deployed there with no fear of the Typhus threat due to advances in preventative medicine championed and pioneered by the scientists of the Sanitary Corps.[53]

The formation of the Sanitary Corps, like the Ambulance Corps, was a major step in military medical advancement. As medical science progressed further, "the diversification of medical specialties in turn reflected the enormous improvement in scientific medicine," and "the practical benefits of medical progress to the Army were immense."[54] The Sanitary Corps can be credited with allowing wartime physicians to focus on treatment and not to worry about preventing epidemics of infectious disease amongst the ranks. As a result of the Sanitary corps institution,

[51] Ibid., 66.
[52] Ibid., 57-80.
[53] Ibid., 66.
[54] Ibid., 81.

General Gorgas later boasted that "the medical Department had prevented a half million cases of disease and saved ten thousand lives in the first six months of mobilization alone."[55]

The U.S. entered the World War I prepared for expanding military medical forces as the need arose. However, the degree to which such unforeseen inefficiencies cropped up throughout treatment, transport, and prevention, was evidence of the work left to be done. Fortunately the continuation and expansion of policies put into action in the Civil War era, along with response to growing medical technologies, enabled an effective and flexible medical force to arise and meet these unforeseen needs. It would, however, only be through the retrospective reflections of peacetime that the medical department would recognize the utility that these military expansions had provided them.

Unfortunately, peacetime was fleeting; as the world erupted into war for the second time, the United States military looked to avoid falling into the same foot-traps of World War I. The U.S. military medical department prepared when war erupted in Europe in 1939, thus by the time Japan attacked the United States at Pearl Harbor in 1941, the medical department had anticipated the coming burden.[56] The conflict rapidly progressed to such a scale that by the end of WWII the medical department had grown to over 800,000 personnel. Additionally, the challenge of providing care was not only in the field of operations. For the first time in recorded

[55] Ibid., 81.
[56] Ibid., 119.

history, civilian deaths totaled higher than military deaths with the course of the World War II.[57]

As the war progressed in Europe, the United States continued to develop its *utility* focused care. The Medical Department became a "massive industrial organization" to keep functioning under the demands placed upon it.[58] The Army essentially doubled down on its previously accepted triage and transport system focusing on an expedient chain of transport that was under complete medical control. The zones of treatment established by medics in World War I also expanded to include two new echelons of care. This system consisted of five medical zones small to large: company aidmen and stations, division medical battalion, evacuation hospitals, the general hospitals (communication zone), and finally the general hospitals stateside (zone of the interior).[59] This expansion of the medical chain also, unintentionally, forced triage decisions to be made more frequently and in much greater volume. With care focused on utility and speed, "sorting of the wounded by severity of injury occurred constantly at every level."[60]

During the course of the war, however, some large and unexpected consequences of this strategy emerged. Physician misappropriation became a continual problem as the expediency focus of the system placed heavy triage demands upon the physicians in the forward echelons. The United States, by virtue of its utility focused system, was forcing physicians to spend more time playing the role of company director and logistical coordinator than patient focused physician.

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[57] Ibid., 119.
[58] Ibid., 119.
[59] Ibid., 120.
[60] Ibid., 120.

Thus, during the time of the largest injury strain ever, U.S. physicians were locked in a position to serve the least. This misuse, and the pressures it put on interior physicians, did not go unnoticed. In 1942 Services Commander Lieutenant General Brehon B. Somervell selected a panel to investigate the source of these problems.[61] Aimed at elucidating the depth to which physicians were being under/mis-utilized, the study found that, "Fully half of the medical officers in the field are wasted and few have the opportunity to do more than glorified first aid work."[62] The situation was so bad that even the American Medical Association weighed in on the potential drafting of medical doctors. They rebelled at the misuse, and attempted to prevent competent physicians from being placed in lines of duty where they would be forced to watch their clinical skills deteriorate.[63] Thus the Medical Department was under considerable pressure to install a major overhaul of their current treatment system. However, instead of examining the conflicts that arose between a utility-centered system and patient-centered physicians, the department endeavored to overcome this misuse through the conversion of duties from physicians to the Medical Administrative Corps (MAC).[64] It was hoped that by creating more specialized individuals to lift burdens from the physicians, there would be a reduction in the number of conflicts caused by this disconnect.

Physicians were now being freed of almost all non-clinical duties within the rapidly expanding WWII medical system. Now, the logistics of expansion that were handled so inefficiently by misappropriated physicians were transferred to

[61] Ibid., 121.
[62] Ibid., 122.
[63] Ibid., 122.
[64] Ibid., 119-148.

specifically trained medical administrative personnel. Perhaps most surprisingly, the change was met with a large degree of physician resistance. Army physicians within the combat and communication zones offered the most resistance. Having become comfortable within their administrative duties, many offered resistance because they had become, "unsuited for clinical duties either through incompetence, failure to remain current, or both[65]". Despite physician resistance, increasing homeland pressure for efficiency was enough to force the MAC changes into the military/medical structure. This eventually allowed for Army physicians to be used in a matter more suitable to their clinical training.

Finally, by the end of WWII, the U.S. learned the last of its crucial medical lessons. Through trial the military found this system of triage and treatment required a heavy reliance upon a well-maintained, non-physician staff of medical administrators. This essential cog was fostered in WWI and allowed to die out during the interwar years. The military learned through the administrator's absence the crucial logistical role they played. Restored, revived, and revamped for WWII, this system was definitively entrenched. In this military medical system, physicians remained as patient-centered as possible within the overarching utility-focused mission. Thus the fundamental layers of the U.S. military medical system came to completion. Continued expansion and refinement occurred along the U.S. path of engagements post WWII. But, by the time the U.S. left the last "global" conflict, their system for militant medical care was tested and vindicated in the eyes of many, affirming utility focus as its priority.

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[65] Ibid., 123.

However, though some proponents argued historic accomplishments of the system as self-evident validity, others began to see conflicts emerging in the ethical hierarchy. The medical system that emerged from WWII necessitated a drastically different mode of ethical discerning than physicians had come to accept. This conflict stemmed from the emergent implications of the physician ethic, and the required deference to the military's utilitarian goals. Many physicians argued against this deference, and pointed to the historical precedent of the physician-patient relationship as evidence of the need to consider other ethical obligations of higher priority. In other words, as the scope of wars increased, physicians became more acutely aware of the problems inherent in treating a patient versus treating a soldier under bureaucratic military command.

Chapter III: The Patient-Physician Ethic

The United States developed a specialized and utility-based transport medical system that proved itself on more than one occasion. Grandpa Harold (like many GIs) was well acquainted with medical transport and treatment within the military, seen above while he sits outside a London hospital. However, the doctors that were (and are currently) required to participate in the system are a separate side of the dilemma. The act of healing is a unique human act and therefore lays claim to an exclusive set of moral presuppositions that govern all patient-physician interactions. The ethical obligations doctors assume by practicing the art of healing

have their own history and governing codes that must first be considered in order to accurately judge the role physicians ought play in the military.

The physician archetype can be understood in many roles, from scientist to businessman, but physician-as-healer is the ultimate role. The idea of a special ethical relationship between patients and physicians originated with Hippocrates and his oath.[66] Throughout the years this oath changed one way or another. However the lasting effects of Hippocrates oath are those he wouldn't have predicted. By separately defining this human interaction of healing as unique, Hippocrates opened the door to the fundamental idea that this ethic needed clarification. However, the ethical clarifications of the many medically based oaths were not explored in any substantive way until recently. For much of the history of medicine, patients simply relied upon the good will of those who offered medical services. As often as not this lead to miscommunications and malcontent, and out of this stemmed the different patient-physician archetypes (businessman, scientist, healer, ect) based upon different cultural emphasis within the same Hippocratic ethic. These multiple ethical sets existed until very recently as unexamined truths. Expanding interest of philosophers and new social views provoked by challenges such as abortion legitimacy encouraged a closer examination of the ethics involved in this healing interaction, in all its facets.[67] For the purpose of this work, the focus will be on the implications of the three acts of the patient-physician relationship that

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[66] Amoroso, *Military Medical Ethics*, 5.
[67] Ibid., 5.

define the ethics involved: "(1) the fact of illness; (2) the act of pro-fession; (3) the act of medicine."[68]

Under this patient-physician set of ethics, the patient physician relationship is, "the final arbiter of the moral status of every policy affecting the health of individuals or the public."[69] And the relationship begins with the fact of illness. Illness is a normal part of humanity. However, it is a state of being that lessens our humanity in multiple ways. "Being ill creates anxiety, fear of mortality, and disability… Illness threatens the idea of one's physical and emotional integrity."[70] So a person who recognizes oneself as ill acknowledges a lack of freedom and a fear of the unknown. Illness slowly becomes the center of one's life until all other normal functions are forced to retreat in the face of this loss of ability.[71] In this state of affliction functioning is possible, but not for an extended period of time. Eventually, "most (patients) decide they need help."[72] By seeking help the patients implicitly recognize some lack of knowledge or ability that they need to restore their body to natural function. Additionally they approach the physician in a time of need from a position of inequality in a specialized need, trusting in one who proclaims certain abilities towards this end.[73]

This leads to the second defining piece of the patient-physician relationship, the act of profession. As a medical professional, be it Hippocrates or a modern neurosurgeon, the act of asking, "How can I help?" invites the patient's trust that the

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[68] Ibid., 11.
[69] Ibid., 5.
[70] Ibid., 11.
[71] Ibid., 12.
[72] Ibid., 12.
[73] Ibid., 11-13.

questioner possesses the needed knowledge.[74] Additionally, by offering help the patient is seeking, the physician accepts responsibility for the patient in a way that, "makes the physician an accomplice if harm comes from the relationship."[75] So the act of profession of knowledge is a reciprocal acknowledgement; first the patient acknowledges the need for expertise, and secondly the physician assumes the responsibility to heal the patient in the most complete way possible.

The final piece consists of the act of healing. This is the recognizable portion of the relationship for most individuals, and perhaps the least implicit pillar. The ideal goal of medicine is of course restoring the health of the patient. In the general sense, the end of medicine, "…to be authentic…must be defined in the terms of the good of the patient, that which restores health…or provides comfort and care if restoration of health is not possible."[76] The good of the patient, while a worthy goal, can often be hard to elucidate. "Good" is an ambiguous term that implies several tiers of evaluation: "the medical good, the good as perceived by the patient, the good of a patient as a human, and the good of the patient's spiritual nature."[77] Surprisingly, the most important process of healing deals not with the medical good, but with the good of the patient as a rational and sentient being.[78] Due to the inequality of knowledge between the patient and physician, the responsibility to respect the patient's individual autonomy is paramount. This final act of deciding

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[74] Ibid., 12.
[75] Ibid., 12.
[76] Ibid., 12.
[77] Ibid., 12-13.
[78] Ibid., 13.

upon not just the "right" decision, but also the "good" decision in the fullest sense of the term is the act of healing.

This then is the complete picture of the patient-physician relationship, and the ethics established through the actions undertaken. Through communication and recognition, the physician enters into a partnership with the patient and promises services to work towards restoration. Physicians, by nature of their specialized knowledge in this venue, are called to be more than simple care providers. They enter an association that demands adherence to these timeless ethics in order to preserve life and liberty of their patient. While this is an idealized goal, the complete relationship described is still the standard for medical education today. The concrete outline of medicine's future is vague, but as long as illness is a fact of life, "the need of sick persons for human interaction, intercession, and counsel will remain."[79] Civilian or military, this is the relationship physicians are called to enter and these are the ethics they are called to uphold. Circumstances may call for different approaches, however the uniqueness of the healing interaction requires an equally unique awareness for its ethical foundations and demands.

So how does this relational ethic work in the context of soldiering? Is it possible to adhere to both ethical systems and simultaneously respect their demands? Military physicians are forced to navigate these waters, and address the questions daily.

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[79] Ibid., 13-14.

Chapter IV: The Dilemma

Legend claims the Persian King Artaxerxes, seeing an epidemic sweep his country, sought the help of the renowned physician Hippocrates. Hippocrates then made a famous decision to deny Artaxerxes' request to ease the plague of the Persian people.[80] Greece, at this time a mortal enemy of Persia, demanded Hippocrates' loyalty above and beyond his physician ethics. In this famous first clash between the emerging physician ethic and age-old nationalism, patriotism triumphed and Hippocrates was blessed for his decision.

Is this the way we expect physicians to act today? Much has changed with the development of the explicit patient-physician relationship. While Hippocrates' choice was much praised by his fellow Grecians, modern physicians are encouraged, if not implored, to consider patients on the terms of their illness and with respect for their innate human dignity.[81] But, is this always the case? Often in today's society physicians are being pulled in more than one direction. That is to say, their moral decisions are not always free and objective. Do we really believe that physicians who are paid by corporations based upon the number of sick-leave days they prevent are acting without influence of another social system? In the words of Doctor John McLaughlin, "Often the first things a doctor forgets are the oaths he took in medical school."[82] Despite the persistent presence of the truly immoral, most civilian physicians can escape this "mixed agency" by referring patients or

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[80] Ibid., 294.
[81] Ibid., 13-14.
[82] Dr. John McLaughlin

resigning from conflicting duties.[83] However, how do military physicians deal with this dilemma? They cannot simply resign, and referring patients in a triage-based system is impractical and often impossible. This is the first ethical issue, among many, that physicians who take up the mantel of the military face. Is it possible to assume the dual role of physician, and of soldier?

The United States Army Medical Department trumpets the motto, "To conserve the fighting strength" as their mission statement. Immediately conflicts begin to develop for the physician trained to put patients first. Implicit within that motto is the belief that the individual army member is to be considered in light of the aggregate force of the whole, not as a single entity. No mention is made of healing the wounded or caring for the sick, but rather the focus, as is proper for a military institution, is placed upon the collective strength of the whole. How can one reconcile this with the defined purpose of a physician, "to serve the best interests of the patient as both the physician and the patient define…"?[84] Typically the tasks associated with the military's need, and the patient's need, are compatible, but in the rare occasion that they are not… what happens then? What happens when the contingency of a situation exceeds the premeditated prescription?

In North Africa, during WWII, massive injuries accrued, and at the same time venereal disease ran rampant.[85] Physicians faced a choice, did they use the limited supply of penicillin to sanitize chest-wounds, or did they save their antibiotics to combat the many instances of venereal disease? According to the ideal patient

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[83] Amoroso, *Military Medical Ethics*, 295.
[84] Ibid., 295.
[85] Ibid., 297.

physician relationship the choice would have to be made on a case-by-case basis, allowing the good of the patient to determine the outcome. In a military that champions a conservation of the force, often the antibiotic was allotted to fight the venereal diseases it could easily treat, and thereby return soldiers to duty.[86] This example is not meant to judge the ethical validity of either choice, but rather to point out the conflict of interest a physician necessarily assumes when he chooses to partake in such a system. The military physician, despite attempted ethical devotion, cannot escape the demands of the military system. Indeed the clash of ethical focus is rooted in an even deeper disparity of purpose. Physicians exist to restore, while the military exists to protect, by means of force. As oversimplified as this seems, the ethical dilemmas physicians face stem from this fundamental disconnect.

While fairly recent in its elucidation, this disconnect has a long and explicit history. In 1949, 60 nations (including the United States) signed onto the Geneva Convention accords that included a list of special rights and obligations for military medical personnel.[87] For the purposes of this argument, one of these obligations will be explicitly stated,

1.) *Regarded as "noncombatants," medical personnel are forbidden to engage in or be party to acts of war...*[88]

At first glance, the statement that physicians cannot be combatants seems almost a rejection of an oxymoron. Of course doctors are not allowed to partake in the

[86] Ibid., 297.
[87] Ibid., 301.
[88] Ibid., 301.

destruction, through combat, of the human lives they protect. However, upon a closer examination, the secondary clause in that quote provides some tension. If physicians cannot be party to acts of war, how can they assume the mantel of the military? Returning to the overall mission of the army, to maintain the fighting force, the overarching structures begin to clash. Even military physicians who find it possible to navigate these ethical waters must recognize ultimately that their ability to decide what they will or will not be party to *isn't in their control*. Unfortunately, the military has a history of blurring the lines between combat soldiers and non-combatant medical personnel.

In engagements after WWII, the military sought to subvert the will of the people, and similarly to win the hearts and minds of the indigenous peoples. This strategic goal heightened in importance as the United States moved into the Vietnam arena especially. One particularly important facet of the campaign relied upon the use of medicine as a catalyst for cultivation of good will.[89] This sounds like a winning strategy seeing as wars are particularly difficult to fight on foreign-nationalistic soil. At face value, what could be wrong with such a strategy? Unfortunately, this strategy relied heavily upon the creation of a new Special Forces unit that quickly devolved the previous separation of healer and soldier.[90] This soldier, the aidman, was required to have learnt basic aid skills and was directed to administer aid *only* as appropriate to the success of the mission.[91] Aidmen were expected to provide basic care to the populations within the villages that they

[89] Ibid., 304.
[90] Ibid., 304.
[91] Ibid., 304.

encountered. It is important to note that while the Army may not see basic healthcare as implicit with a healthcare provider, the same cannot be said for the beneficiaries of this conditional care. Temporary wound maintenance, burn care, and basic antibiotics, while not exclusive tools of medical personnel, imply involvement in the act of healing and thereby fall under previously discussed ethical considerations. Thus, by creating a combatant, and also charging that combatant with the responsibility of medical practice (however rudimentary) the military effectively violated two of the utmost ethical promises they had made. First, they blurred the lines between non-combatant, and combatant roles within the military without having to directly arm physicians. Secondly, they began to use medicine as a weapon of will. By arming healers, in however simplistic the terms, the U.S. military diminished the exclusivity and trust of the patient-healer relationship. The confusion of native peoples as to the purpose and scope of these aidmen was intentional. Who they were and what purpose they served was intentionally obscured as they treated those who showed the U.S. favor, and acted as soldiers against those who didn't. In addition to serving a dual purpose, withholding treatment with the intention of causing harm or giving treatment under the forced promise of loyalty, is inherently unethical. Despite the aid these Special Forces units were undoubtedly bestowing on the native (Vietnamese) people, it came at the price of demeaning the ethical patient-physician relationship, and turning it into a weapon of a larger social goal.

As a civilian physician, this type of practice would never stand. The good done by the physical deeds of healing cannot excuse the implication of the

subversive medicine. By devaluating the act of healing, the relationship between the patient and the care provider is undermined, and as a result the interaction loses its purpose and is corrupted. Howard Levy, a dermatologist drafted in 1967, recognized the subtle and sinister misappropriation of ethics.[92] Capitan Levy refused a direct order to train these aidmen on the grounds that he could not justify enabling what he called the erosion of medical ethics.[93] Capitan Levy felt that a physician "is responsible for even the secondary implications of his acts…"[94] Due to this stance, Capitan Levy was tried in military court (U.S. v. Levy) and sentenced to serve three years in military prison.[95] With this powerful statement, military physicians were definitively told that their ethics, their decisions, would only be allowed to the extent that they complied with their orders. Anything else was not only discouraged, but was punishable by law. The importance of this governmental decision cannot be overstated. By setting precedent in this manner the standing operating procedures for physicians were limited and defined to orders. Without the ability to judge a situation based upon the circumstances, military physicians lost their ability to truly focus on the patient as an autonomous being.

Herein lies the most central problem of this study. Under such circumstances, is it really possible for physicians to operate, ethically, under a military banner? The problem at stake is one of much greater consequence than

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[92] Ibid., 304.
[93] Ibid., 304.
[94] Ibid., 304.
[95] Ibid., 304-305.

this author initially suspected. What began as an inquiry into an apparent miscommunication now moves to a justification of existence. How do military physicians exist in such a divided, quietly compliant role… even simpler, can they?

Chapter V: The Reality

It would seem, upon careful reflection, that the duality of a system that is both military and medical simply demands too much. In such a system a healer must respect the patient fully, as is called for through the physician ethic, and at the very same time be compliant to the overall goal of the militant mission. For the reasons listed previously, and many more excluded from this study, the feat seems impossible. Yet, these types of military physicians do exist. Even within my own family the dilemma was penetrant—my grandfather served as a medic during his time, while my grandmother and her sisters, portrayed above, were all nurses. Our

military is similarly full of physicians who somehow come to terms with these problems and either overcome them or ignore them. More fundamentally, these physicians play a crucial role in the success and protection of our society's freedoms. These men and women serve and protect in a way far and above the singular call of the civilian doctor, or even the simple soldier. So how is this possible?

Karl Marlantes hints at a resolution in his book *What It Is Like To Go To War*. Although not a physician, or medical personnel, this portrayal of his Vietnam experience lends insight into the extremity of conflict, and the realm of existence war evokes. As a defecting Rhodes Scholar, First Lieutenant Marlantes recounts his experiences leading Marine Company C as an executive officer. Marlantes writes,

> "*Warriors deal with death. They take life away from others. This is normally the role of God…*"[96]

The importance of this statement cannot be over stressed. Soldiers are asked, through the war experience to partake in a unique set of circumstances completely outside of the human condition. To play the role of God in one way or another, which the act of war necessitates, evokes a mode of action outside of the understandable, beyond comprehension. Veterans talk to veterans because the feelings, the actions, the decisions undertaken in war, are unexplainable to those who were not there.

Although physicians are not soldiers, and the United States' Army still proposes segregation of combatant and healer, there is an overlap of extreme

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[96] Marlantes, *What it is like to go to war*, 1.

circumstances in the work a soldier does, and the work a healer does. While soldiers 'deal in death,' physicians also enter into an extreme mode of action, 'dealing in life.' Soldiers take on the mantle of God through causing death, and physicians emulate Him by maintaining life. War, for the physician, is the ultimate duality of both fringes of human experience—dealing out death as a unit, bringing life as an individual.

Karl Marlantes argues the necessity of segregating the roles individuals play in this war circumstance from the rest of human experience, thereby clearly implying that the extremity of war demands its own set of rules. How can I sit idly at my computer, safe and free, and tell military physicians they cannot practice their craft? The simple answer is, I can't. Just War Doctrine tells us the difficulty of waging a just war, and even in the best of cases, war is still an evil tool. Perhaps, in such circumstances, perfection is not attainable, ethics aren't always reasonable, and experiences exceed our ability to attain justification.

After examining the multitude of steps that led to the current system, my severest critique lies within the fundamental structure. In a perfect world, I envision a system of simplicity in which physicians operate alongside the armed forces rather than under their direct control. That is not to say that they are in any way superior, rather the separation would ensure the physicians would be relieved of this mixed agency—free from adherence to any principles other than those implicit in their training, their patient focused oaths. Operating under this dogma alone, perhaps 'care of the individual' could replace 'preservation of the fighting force' as the primary mode of healthcare delivery. However, this is not a perfect world. It may be

possible that, while our military medical system will never be perfect, it exists within a war experience that condemns perfection. This is not to say that change is not needed: Specialist Clark's death cannot be in vain. However, continual pursuit of medical liberty, of more effective care in the extremity of war, may be the best mode of action to redeem the system as it is.

Martin Buber, a prominent Jewish philosopher and rabbinic figure, speaks to this paradox saying, "…the world of ordinary days affords us that precise association with God that redeems both us and our speck of the world. God entrusts and allots to everyone an area to redeem."[97] In these *ordinary* days, God has placed us here in a *precise* position to work towards redemption. How much more precise is the relationship then, in the military medic's, the battlefield surgeon's, the triaging nurse's *extraordinary* days? In the end, we have to allow ourselves to believe that God truly does entrust an area of redemption to each of us. When logic fails, when the circumstances of war seem to drown traditional ethics in a sea of irrelevance, we must take comfort in the fact that the individuals providing the medical needs to our military community, are allotted by God to that precise association.

As I continued to read my grandfather's diary entries, it was difficult for me to come to terms with his helplessness. It was evident that he was a brave soul trying to make sense of his situation, too proud to seem weak, too embarrassed to seem ignorant. Reading about his experience made it difficult to distance myself emotionally from the arguments at stake. Every time I read his struggles, I feel his pain, and my disdain for the utilitarian system we developed grows. Yet, as I strive

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[97] Dillard, *For the Time Being*, 201-202.

for partiality, as I examine the facts of my life, I find I am forced to reassess. I owe my very existence to the medics that stemmed my grandfather's bleeding in the field, the transporters who brought him back to a field station, the doctors who operated numerous times on his legs, and the rehabilitation teams that aided him in recovery. It is because of them, because of that system, that I am here. So now I come to the ultimate crux of the inquiry. If I condemn the system at large for the injustices that are inherent in its utilitarian function, I condemn the very system that enabled my family to place me here. Should I stake that claim?

My grandfather talked about his war experience only once that my father could remember. Sitting down at a table with his brother they recalled some of the less gruesome times they spent in France on the trail to Germany. My dad recalls a respect in my Grandpa's voice for the men and women that rescued him, healed him, and restored him. Not the respect born out of adoration, but rather a mutual respect, as if for someone who bore an incredible burden. He didn't understand his situation at the time, and he remained ignorant of the details until the day he died; yet he respected these men and women because they rose to meet their unbelievable circumstances, to redeem their world. I think this is the statement I can give concerning the military medical-physician system. I cannot justify the physician at war or the military medical system, however I also cannot justify war. Therefore, as long as war exists, I am grateful that some men and women *can* navigate this treacherous ethical field. I owe my life to them.

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