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# Damage Control Interdisciplinarity: An Antidote to Death Despair in Military Medicine

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# DAMAGE CONTROL INTERDISCIPLINARITY: AN ANTIDOTE TO DEATH DESPAIR IN MILITARY MEDICINE

ERIKA "ANN" JESCHKE*

ABSTRACT

*"Diseases of despair" is a conceptually broad category used to describe the phenomenon of premature mortality caused by suicide, drug poisoning, and alcoholic liver disease. Central to this conceptualization of mortality is that death occurs too early in an entire population of individuals infected with social despair. Implicit in the diseases of despair construct is a powerful normative claim about the manner and time of death—that death is bad if it is contextualized in unwanted conditions and happens before reaching midlife. As such, diseases of despair ought to be reduced, if not eliminated. Interestingly, military medical research on combat casualties abides by a comparable normative understanding of mortality—that combat provides a less than optimal context in which to die and that those who die on the battlefield do so too young. In response to this implicit normative ideal, military medical research and practice have made major strides in developing effective life-saving interventions in the past twenty years. Service members' lives are saved after catastrophic injury due to advances in the combat damage control medical paradigm. The achievements of this paradigm are enshrined in an overall ninety-two percent survival rate for service members injured in Iraq and*

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*Afghanistan and have initiated interest in achieving zero preventable deaths after catastrophic injury in both military and civilian medicine. While medical achievements in Iraq and Afghanistan are laudable, primarily focusing on achieving zero preventable combat deaths constructs a military-medical culture wherein the despair of death is implicitly woven into military health policy, training, and organizational culture. This article will explore the* complex challenge *of addressing death despair in combat casualty management. I develop a modest argument suggesting that to effectively shift expectations relative to death and dying in casualty management, the Defense Health Agency needs to support interdisciplinary research that focuses on strategic second-order organizational change before developing health policy and medical training in preparation for future large-scale combat operations. In specific, I suggest that this interdisciplinary team needs to be led by academic experts in anthropology, history, and political science in collaboration with military medical and strategic experts.*

## I. INTRODUCTION

"Diseases of despair" is a conceptually broad category used to describe the phenomenon of premature mortality caused by suicide, drug poisoning, and alcoholic liver disease.[1] Literature on this topic has traditionally investigated despair as a population-based pathology affecting the health of entire segments of society as a result of economic stagnation. Central to this conceptualization of mortality is that death occurs too early in an entire population of individuals infected with social despair. Implicit in the diseases of despair construct is a powerful normative claim about the manner and time of death—that death is bad if it is contextualized in unwanted conditions and happens before reaching midlife. As such, diseases of despair ought to be reduced if not completely eliminated.[2] Interestingly, military medical research on combat casualties abides by a comparable normative understanding of mortality—that combat provides a less than optimal context in which to die and that those who die on the battlefield do so too young. In response to this implicit normative ideal, military medical research and practice has made major strides in developing effective life-saving interventions in the past twenty years. Service members' lives are saved after catastrophic injury due to advances in the combat damage control medical paradigm. The achievements of this paradigm are enshrined in an overall ninety-two percent survival rate for service members injured in Iraq and Afghanistan.[3]

Damage control was originally a Navy term coined to describe the process of minimizing and containing the impact of damage to a battleship.[4] The primary goal of this process is to control flooding to preserve the stability and buoyancy of a ship while maintaining maximum offensive power.[5] Like with battleships, damage control medicine seeks to minimize and contain the impact of major trauma sustained to the human body in combat.[6] The initial goal is to stop bleeding and contain contamination to stabilize major bodily functions.[7] Ongoing treatment involves abbreviated operations and intensive care unit resuscitation, followed by definitive surgical interventions.[8] Once a touchpoint

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    1. Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, 2017 BROOKINGS PAPERS ON ECON. ACTIVITY 397, 398.

    2. *See generally* Lilly Shanahan et al., *Does Despair Really Kill? A Roadmap for an Evidence-Based Answer*, 109 AM. J. PUB. HEALTH 854, 854–858 (2019) (highlighting the need for further research into disease of despair).

    3. David Vergun, *Survival Rates Improving for Soldiers Wounded in Combat, Says Army Surgeon General*, ARMY NEWS SERV. (Aug. 24, 2016), https://www.army.mil/article/173808/survival_rates_improving_for_soldiers_wounded_in_combat_says_army_surgeon_general.

    4. Juan C. Duchesne et al., *Damage Control Resuscitation: The New Face of Damage Control*, 69 J. TRAUMA: INJ., INFECTION, & CRITICAL CARE 976, 976 (2010).

    5. NAVAL DAMAGE CONTROL TRAINING CTR., HANDBOOK OF DAMAGE CONTROL, NAVPERS 16191, 169 (1945), https://maritime.org/doc/dc/index.htm.

    6. Duchesne et al., *supra* note 4, at 976.

    7. *Id.*

    8. *Id.*

for controversy in civilian medicine, the combat damage control paradigm was optimized in Iraq and Afghanistan by relying on global aero-evacuation capabilities that allowed for quick battlefield evacuation and transcontinental transportation through several military surgical facilities before arriving at definitive medical care.[9] Due to its incredible success at saving service members' lives, this trauma care paradigm initiated interest in achieving zero preventable deaths after catastrophic injury in both military and civilian medicine.[10]

While medical achievements in Iraq and Afghanistan are laudable, primarily focusing on achieving zero preventable combat deaths constructs a military-medical culture wherein the despair of death is implicitly woven into military health policy, training, and organizational culture.[11] Considering that force protection is an important aspect of military leadership and command, death despair may seem like a frivolous, or even deleterious, research topic. However, if such deaths remain unaddressed, it could lead to a host of concealed and potentially destructive consequences for service members, the military organization, national security, and civilian society at large.[12]

Currently, geopolitical tensions have caused military strategists in the United States to prepare for the possibility of large-scale combat operations (LSCO) akin to battles fought in World War I and II.[13] The future multi-domain battlefield will be distributed across vast geographic terrain and integrate capabilities in air, cyberspace, land, maritime, and space domains.[14] Furthermore, the U.S. will not necessarily maintain dominance on such multi-

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9. Lorne H. Blackbourne, *Combat Damage Control Surgery*, 36 CRITICAL CARE MED. S304, S304 (Supp. 2008).

10. NAT'L ACADS. OF SCI. ENG'G MED., A NATIONAL TRAUMA CARE SYSTEM: INTEGRATING MILITARY AND CIVILIAN TRAUMA SYSTEMS TO ACHIEVE ZERO PREVENTABLE DEATHS AFTER INJURY 1 (2016), http://www.nationalacademies.org/hmd/Reports/2016/A-Nation al-Trauma-Care-System-Integrating-Military-and-Civilian-Trauma-Systems.aspx.

11. It might be better to say reinforces a culture of death despair. While these articles are not specifically about death, they explore the concept of casualty aversion arguing that this phenomenon is not attributable to the broader civilian public, but the military policy and leadership. *See, e.g.*, Richard A. Lacquement Jr., *The Casualty-Aversion Myth*, 57 NAVAL WAR C. REV. 39, 39–57 (2004). *See generally, e.g.*, CHARLES K. HYDE, CASUALTY AVERSION: IMPLICATIONS FOR POLICY MAKERS AND SENIOR MILITARY OFFICERS 16–18 (2000). Implicit in the idea of casualty aversion is despair of death. Lacquement Jr., *supra* note 11, at 39–57; HYDE, *supra* note 11, at 16–18. *See infra* section II of this article for more about despair of death.

12. Albert Palazzo, *No Casualties Please, We're Soldiers*, 5 AUSTRALIAN ARMY J. 65, 66 (2008).

13. *See generally* David G. Perkins, *Preparing for the Fight Tonight: Multi-Domain Battle and Field Manual 3-0*, 97 MIL. REV. 6, 7–8 (2017) (discussing what we have learned from previous World Wars and how it should influence our future preparation) [hereinafter Perkins, *Preparing for the Fight Tonight*].

14. David G. Perkins, *Multi-Domain Battle: Driving Change to Win in the Future*, 97 MIL. REV. 6, 6–7 (2017).

domain battlefields because "Russia and China have developed considerable capabilities for constraining U.S. military strengths."[15] Entering armed conflict with a near-peer enemy poses many challenges to military medicine not present in counterinsurgency operations (COIN), making the practice of medicine frighteningly more complex.[16] The strong possibility of anti-access and area denial would force greater distances between medical care facilities and degrade the current global transport system.[17] In other words, it will be impossible to sustain the combat damage control paradigm that provides life-saving care to catastrophically injured service members because the military will not have the luxury of quick medical evacuation to a higher level of combat casualty care. Military medical experts within the Defense Health Agency (DHA) project that fighting a near-peer enemy on a multi-domain battlefield could result in thousands of casualties at one time and up to 40,000 casualties per month.[18] Amidst such conditions, tactical necessity will restrict medical access, govern distribution of scarce medical resources, and compel reverse triage—providing care to the least injured first—to conserve the fighting force.[19] The practical outcome is that death will become an ever-present reality for military care providers who are serving far forward on a multi-domain battlefield.

This article will explore the *complex challeng*e of addressing deaths of despair in combat casualty management as the U.S. and its North Atlantic Treaty Organization (NATO) allies prepare for LSCO on a multi-domain battlefield with near-peer enemies. What I have noticed from my initial phase of research on the topic of casualty management in LSCO is two interlocking needs that ground all other research, training, and policy discussions moving forward. First, there needs to be a shift in expectations around death and dying when discussing the nature of catastrophic injury and specifically, to include death not only as a medical possibility in relationship to catastrophic injury, but also a central aspect of medical decision-making in LSCO. Second, there is a need to create a comprehensive conceptual map of the broad spectrum of challenges that must be addressed in shifting these expectations. In this article, I develop a modest argument suggesting that to effectively shift expectations relative to death and dying in casualty management, the DHA needs to support interdisciplinary research that focuses on strategic second-order organizational change before

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15. Perkins, *Preparing for the Fight Tonight*, *supra* note 13, at 10. *See also* Jim Garamone, *Work Details Multidomain Battlefield of the Future*, DOD NEWS (Oct. 4, 2016), https://www.de fense.gov/Explore/News/Article/Article/963806/work-details-multidomain-battlefield-of-the-future/.

16. Todd E. Rasmussen et al., *Combat Casualty Care Research for the Multidomain Battlefield*, 83 J. TRAUMA & ACUTE CARE SURGERY S1, S1 (Supp. 2017).

17. *Id.*

18. Col. Michael Davis, Ever Adapting for the Warfighter: Future DoD Medical Battlespace Preparedness (Sept. 24, 2019) (unpublished manuscript) (on file with author).

19. *Id.*

developing health policy and medical training for LSCO. More specifically, I suggest that this interdisciplinary team needs to be led by academic experts in anthropology, history, and political science in collaboration with military medical and strategic experts.

## A.    *Personal Orientation to Research*

The genesis of my interest in this topic took place two years ago at the Military Health System Research Symposium when an audience member asked a combat casualty care researcher whether the American public was prepared for future mass casualty scenarios in LSCO. As I spoke with this researcher, he shared his concern that the Ranger Regiment, which has achieved zero preventable combat deaths, may have created an even bigger dilemma. This individual feared that the lack of familiarity with death and dying would likely overwhelm inexperienced military care providers thereby negatively impacting their performance. Since that day, I have been attempting to better grasp the importance of explicitly acknowledging, accepting, and preparing for death as a possible outcome in battlefield medicine.

My long-term project is to develop an intricate set of interwoven arguments for why medicine needs to be at both the international and national strategic planning table when discussing LSCO. In the past, the critical role medicine has played in military operations has been drastically undervalued, if not summarily overlooked. Recently, I read the book *Block by Block: The Challenges of Urban Operations*, in which the editors posed a set of normative questions that must be explored in order to ethically and effectively prepare for future combat.[20] Although implicit in every question posed, medicine was nowhere to be found.[21] It is my overarching contention that ignorance of the central role medicine plays in armed conflict is only to the detriment of our military missions and national security. Furthermore, it obstructs the ability to develop informed, effective health policy that guides just and humane responses to the human cost of warfare.

Being an interdisciplinary scholar who speaks to and writes for many different audiences, experience has taught me that those unfamiliar with the intersection of academic military, including ethics, medicine, strategy, and health policy may be skeptical about my agenda or the purpose of my scholarship. At a recent military conference, many audience members thought I was suggesting that the current orientation toward death in casualty management was unethical, while others pressed for "the right answer." The largest group was stymied by my topic, suggesting that preparing for death in LSCO was not an ethical problem but one of expectation management which had nothing to do

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20.  *See generally* DONN A. STARRY, BLOCK BY BLOCK: THE CHALLENGES OF URBAN OPERATIONS (William G. Robertson & Lawrence A. Yates eds., 2006).

21.  *Id.*

with morality. In other words, my work did not fall within the realm of what was deemed as proper ethics research. At a military ethics conference, I was told that medicine does not belong in military ethics, which focuses on the appropriate amount of violence to be used when subduing the enemy or what weapons should be developed in response to future threats. Similarly, when talking to military strategists, I mentioned that military care providers perform tasks central to national security, and I questioned why military medicine was nonetheless omitted from strategic planning for LSCO. My insights and questions perplexed those present because they had never considered how medicine might impact national security or be essential to military strategic planning. Finally, my academic colleagues who focus on health policy fear that researching the medical realities of LSCO is akin to a self-fulfilling prophecy. Catherine Lutz well captures the ethical paradox implicit in preparing for future conflict scenarios by saying that such activities must "draw on culturally tutored imagination, fears, and wishes" that constructs a situation where "experiments on new forms of violence might work."[22] I believe the implicit fear is a belief that in researching the ethics of mass casualty, that I might be ethically supporting LSCO as the necessary and good outcome of international policy.

My point in relating this information is not to resolve the inherent paradoxes of my chosen inquiry but to clearly establish that I recognize that my topic and method is contentious to many people on numerous levels. For this reason, I want to explicitly clarify how I understand my role as an academic military medical ethicist to lay the groundwork for what you, the reader, can expect from me. My analytic goal is to bring to light various challenges in the provision of medical care on the future battlefield. My deliverable is provided in the form of argumentative papers that are meant to explain why certain actions should or should not be taken. From my view, all things are open to ethical evaluation and argumentation. While arguments can serve to justify actions or the direction of research, funding, training, and policy, they rarely—if ever—provide final answers about ultimate truth, goodness, or rightness. Instead these arguments give shape to often amorphous problems in the applied world of research. As such, I value the discipline of ethics not simply because it sifts through information to construct valid and sound arguments, but also because the process of exploring complex, often unanswerable questions, helps prepare for the morally murky game of life.

Being an interdisciplinary scholar, I see my role as one in which I help guide my broader audience—in this case, military and policy stakeholders—through the following process: to ask critical questions to clearly define abstract concerns, to determine to whom the questions need to be addressed, and to explore what methods of research will allow theoretical questions to be

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22. CATHERINE LUTZ, HOMEFRONT: A MILITARY CITY AND THE AMERICAN TWENTIETH CENTURY 87–88 (2001).

translated into practical and concrete outcomes that provide scope for effective informed training and policy. While many of you may disagree with my academic orientation on ethics, I hope my analysis evokes passionate and inquisitive responses to this multi-layered topic.

## B.    *Assumptions, Objections, Counter-Objections*

The world of battlefield medicine—particularly, casualty management—is ostensibly one of the most complicated moral grey-zones, with few black and white solutions. Nonetheless, medical decisions must be made, acted upon, and lived with while operating in the proverbial fog of war. Being a just war theorist[23] who is open to the possibility of justified violence in support of national security, I believe there is an appropriate role for medicine to play in preparing for and responding to the human carnage of war. While my topic does not precisely fit within one domain of just war analysis, I am assuming that if the U.S. engages in LSCO with a near-peer enemy, then such a conflict would achieve the *ad bellum* criteria of ethical justification. Even if justified, not all actions *in bello* are justified. Therefore, I also assume it is essential to critically evaluate how military medicine ought to appropriately support national security interests. These assumptions allow me to evaluate questions pertaining to how military medicine ought to prepare for and engage in casualty management in LSCO.

Turning to the specific topic of this article, I am not going to argue that expectations around death and dying must shift in order to effectively manage combat casualties. I am simply assuming this is a necessary function of preparation for LSCO. The assumption that addressing death despair is critical to national security does not imply that casualty management primarily focused on life-saving medical interventions is inappropriate or unethical. It is simply that different battlefields require different ways of practicing medicine in relationship to catastrophic injury. I anticipate that some of you will disagree with my assumptions. Amongst military medical audiences, there have been two common rejoinders to my topic of research to which I will respond.

The first is: "Why do we need to train clinicians to deal with death? Human beings are adaptive. They will figure out what to do!" I agree that human beings are highly adaptive, but adaptation at its best is a function of intense training that engenders a sense of certainty in one's excellence. I absolutely believe that the trope "Let them Adapt" is as ethically callous when considering the casualty

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23. *See generally* A.J. COATES, THE ETHICS OF WAR 2 (2d ed. 2016) (discussing St. Augustine's foundational role in establishing the just war theory as a moral good, such as with the principle that "just war is consistent with an ethic of love, involving as it does the willingness to die that others might live."). *See also, e.g.,* NIGEL BIGGAR, IN DEFENCE OF WAR (2013) (arguing that war can be just when it punishes grave injustice, such as in the cases of conflicts in Rwanda, Kosovo, and Iraq).

numbers that are being discussed in LSCO. Furthermore, such a notion of adaptation is akin to asking a ten-year-old with only introductory piano lessons and little practice to perform a Bach composition with proficiency. While the ten-year-old will play *something*, they will not fluently make sense of the musical score or excellently perform. If playing Bach is akin to dealing with death and dying, clinicians will have some metaphorical musical training, but without shifting expectations from life-saving to death care, those clinicians who are far forward on the future battlefield will not likely make sense of the situations or perform well in the face of mass casualties.

The second is: "It is impossible to predict the future. We cannot know what we do not know." While I agree that we cannot perfectly predict the future or completely control the battlefield, military strategists and planners have been involved in war-gaming other aspects of LSCO. In fact, that is precisely the job of military strategists—to construct hypothetical scenarios that will provide insights into the nature of future conflict for the purposes of preparation. Suggesting that we should not plan for the medical reality of LSCO because we cannot know the future is a huge oversight that is not made of other mission critical aspects of military operations. Furthermore, to think we should only research options that allow complete control of the battlefield misses the entire phenomenology of combat. According to Carl von Clausewitz, the two consistent aspects of the battlefield are the friction and fog of war.[24] His response to working effectively within those constant scenarios is training.[25] As such, military research, strategy, and policy must strike a balance between describing the contours of future battlefield scenarios while developing training that engenders the service member's confidence and operating in an ever-changing environment.

I hypothesize that this rejoinder is common amongst military commanders and military medical experts because military medicine has never had a seat at the military strategic planning table. Consequently, military medicine takes a backseat to the planning while military strategists seek to find ways to increase lethality and capacity on and off the battlefield. Ironically, military medicine is central to dealing with both of those issues. The question is not whether we can predict the future with some modicum of success—that is the purpose of all applied research—but which disciplines are best suited to perform the analysis of the unique and complex challenges of death despair in military medicine.

## C.    *Terminology and Outline of Analysis*

I specifically chose to title this article *Damage Control Interdisciplinarity* because death despair in military medicine could be potentially life-threating to

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24. *See generally* CARL VON CLAUSEWITZ, ON WAR 46, 66–68, 88–89 (Michael Howard & Peter Paret trans., 2007).
25. *Id.* at 68–69.

military missions in LSCO. The implication is that, like naval or medical damage control, interdisciplinary research will be able to outline major challenges that threaten military success and provide effective training and policy solutions for addressing these challenges. By interdisciplinary research, I mean a mode of integrated research that relies on a collaborative team of scholars who possess specialized expertise in different theories and methodologies to advance fundamental knowledge on a complex topic that is beyond the scope of a single discipline or field of research.[26] Important to my argument is the word "complexity." I do not seek to clearly articulate all challenges associated with shifting expectations around death and dying in casualty management. I seek to highlight the enormity of the task and suggest how interdisciplinary research can serve to develop a comprehensive conceptual map of the challenges associated with shifting expectations in casualty management. This map will serve as a metaphorical damage control manual for death despair in preparation for LSCO. Although combat casualty care includes life-saving care for contractors, civilians, and enemy combatants, I base my analysis on injured service members in the U.S. military for two main reasons. First, the implicit normative orientation I am calling "death despair" focuses almost exclusively on injured service members.[27] Second, performing meticulous epidemiological data analysis on long-term outcomes for those not captured in the DHA medical tracking system is beyond the scope of this article and my scholarly expertise.

You will also note, that I am using the broad terms "catastrophic injury" and "casualty management" instead of "expectant casualty" and "reverse triage" throughout this article. The use of these terms is purposeful. In a resource rich environment, medical decision-making is not focused on sorting severity of injuries but on providing the appropriate intervention for all injured.[28] As such, management of catastrophic injuries need not necessarily acknowledge death as a possible outcome. In fact, medical decision-making in resource rich environments tends to focus on doing everything possible to potentiate saving

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26. NAT'L ACADS. OF SCI. ENG'G & INST. OF MED., FACILITATING INTERDISCIPLINARY RESEARCH 26 (2004).

27. Casualty management is similar throughout the NATO partners. *See* E. Falzone et al., *Triage in Military Settings*, 36 ANAESTHESIA CRITICAL CARE & PAIN MED. 43, 45 (2017). I will at times reference the following two works that highlight my global point that death despair is an implicit aspect of casualty management. *See id. See also* EMILY MAYHEW, A HEAVY RECKONING: WAR, MEDICINE AND SURVIVAL IN AFGHANISTAN AND BEYOND (2017); Palazzo, *supra* note 12.

28. E. ANN JESCHKE & SARAH L. HUFFMAN, REIMAGINING 'HONORABLE DEATH' IN FUTURE LARGE SCALE COMBAT OPERATIONS 69, 74 (2019). *See, e.g.*, DEP'T OF THE ARMY, FIELD MANUAL 8-55: PLANNING FOR HEALTH SERVICE SUPPORT 4-5 (1994) (defining "evacuation tenets" and explaining that "[e]vacuation begins at the location where the injury or illness occurs and continues as far as the patient's medical condition warrants or the military situation requires").

life.[29] Classification of an "expectant casualty" necessarily requires the sorting of injured into triage categories that are determined by how severe the injury is in comparison to death—"expectant" meaning that the casualty is expected to die.[30] Triage also, by definition, implies acknowledging the possibility of death and a resource constrained environment.[31] More specific to military medicine, reverse triage implies not only acknowledging the possibility of death, but also accepting it as a foregone conclusion because limited medical resources are given to the least injured in order to return as many warfighters to the battlefield as possible and to conserve the fighting force.[32] In describing the COIN combat damage control paradigm using these broader terms, I am attempting to illustrate that expectant casualty is a specific form of catastrophic injury and that reverse triage is a specific form of casualty management whose distinction hinges on death in austere conditions. More importantly, these distinctions will have radical implications for medical decision-making in LSCO casualty management. If military care providers are not prepared to acknowledge and accept death, they will struggle to perform the decision-making necessary to support mission success in LSCO.[33] For simplicity's sake, I will refer to casualty management as the COIN or LSCO paradigm throughout the rest of this article.

My argument will unfold in the following manner. First, I briefly describe the resource rich context in which the COIN paradigm operates. This section will illustrate how death despair manifests in the COIN paradigm, what expectations are engendered by this challenge, and how these expectations, if not shifted, might hinder military operations in LSCO. To conclude this section, I present a visual diagram that delineates how to capture various component pieces related to the broad scope of challenges associated with shifting expectations in casualty management. Second, I describe a theory of strategic organizational change relative to effective training and policy development to show why it is important that the interdisciplinary research team be led by external academics. I also explain the importance of relying on academics who specialize in the disciplines of anthropology, history, and political science in collaboration with military medical and strategic experts and describe the various roles each will play in the interdisciplinary team. Finally, I will conclude

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29. *See, e.g.*, DEP'T OF THE ARMY, *supra* note 28, at 4-13 (defining "casualty management system" and requiring "[p]rompt movement of patients . . . to avoid increased morbidity and mortality.").

30. MASCAL SOP, U.S. AIR FORCE (Apr. 10, 1997), http://www.usafp.org/previous/op_med /milmedsop/mascalsop.html (defining "expectant" as "casualties who will die in the existing field medical care support system, or would require exhaustive efforts to temporarily extend their life.").

31. BORDEN INST., EMERGENCY WAR SURGERY 29 (4th ed. 2013).

32. Michael S. Baker, *Creating Order from Chaos: Part I: Triage, Initial Care, and Tactical Considerations in Mass Casualty and Disaster Response*, 172 MIL. MED. 232, 232–33 (2007).

33. *See generally* JESCHKE & HUFFMAN, *supra* note 28, at 72–75 (discussing a military professional's experience treating a dying warfighter).

by returning to the construct of diseases of despair to reflect on some of the hidden costs of death despair in military medicine.

## II. THE COIN PARADIGM: DEATH DESPAIR

As previously mentioned, the COIN paradigm has existed in an extremely resource-rich medical environment that has allowed for an unprecedented overall survival rate exceeding ninety-two percent.[34] As Michael R. Hetzler points out: "A controlled, methodical, and scalable conflict has provided almost every known need and cost while extraordinary efforts in lifesaving have become the norm."[35] Providing access to advanced and intensive damage control medical interventions has been predominantly enabled by quick evacuation of causalities off the battlefield to higher levels of definitive medical care.[36] Hetzler also points out that in "the pursuit of ensuring zero preventable deaths" military care providers focus "on the details of therapeutics" and base medical decision-making on the "assumptions of resource availability, clinical expertise in oversight, and the presence of ideal conditions."[37] Consequently, catastrophic injury in the COIN paradigm has rarely included death and dying. Catastrophic injury is more accurately captured in COIN operations by extreme disfigurement or dismemberment of the body.[38] This is not to suggest that death has never occurred. However, the COIN paradigm does not include a robust appreciation or acceptance of the possibility that a catastrophically injured warfighter may be in the process of dying or die.[39] All military medical training, research, and policy singularly focus on life-saving medicine.[40] In fact, the Combat Casualty

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34. Vergun, *supra* note 3.

35. Michael R. Hetzler, *A Case for Improvised Medical Training*, J. SPECIAL OPERATIONS MED., Winter 2019, at 123, 123.

36*. See generally* Vergun, *supra* note 3 (illustrating how quick evacuation has helped our troops in Afghanistan).

37. Hetzler, *supra* note 35, at 123.

38*. See* MAYHEW, *supra* note 27, at intro.

39. Both of the following books explore the impact of casualty management in relationship to individual service members whose lives are saved after catastrophic injury requiring multiple surgeries. Emily Mayhew, a British historian of combat casualty care, looks at five service members from point of injury on the battlefield through rehabilitation in the United Kingdom. Zoë Wool, an American anthropologist, looks specifically at the ordinary life of six injured service members after returning home. These books help establish the singular focus on life-saving medical interventions in relationship to catastrophic injury and provide descriptive detail concerning the nature of catastrophic injury in combat casualty care. *See generally* MAYHEW, *supra* note 27; ZOË WOOL, AFTER WAR: THE WEIGHT OF LIFE AT WALTER REED 19 (2015).

40. In reviewing countless military medical training manuals, calls for research and funded research, as well as DHA policy guidelines, I have yet to see anything mentioned concerning death or dying. Having attended the major military medical conferences for the past three years, I have heard military medical care providers advocate singularly for technological devices that will continue to save lives on the battlefield. I have yet to hear, see, or read anything concerning death in combat casualty care. In fact, when discussing the idea of using the word in training manuals, I

Care Research Program prioritizes research funding for new life-saving strategies focused on advanced "surgical techniques, biological and mechanical products, and the timely use of remote physiological monitoring" to overcome the limitation of death in combat operations.[41]

The normative focus of medical decision-making in COIN, which is saturated in death despair, inadvertently codified the aspirational ideal of "leave no man behind" into an expectation that military care providers can, will, and should save the lives of all injured service members.[42] As such, death despair has established a multitude of expectations that influence the individual, military organization, and civilian society.[43] These expectations influence how military care providers train for, engage in, and return from the performance of casualty manage. Said differently, the result of hiding death and dying from immediate view in relationship to both catastrophic injury and casualty management is multi-fold and is experienced across the deployment cycle. If these expectations are not uprooted and exposed in order to shift expectations in medical decision-making, then death despair will negatively impact the performance of casualty management in LSCO.

## A.   *Loss of Expectant Category of Casualty: Individual, Organizational, and Social Expectations*

One major challenge established in the COIN paradigm is the loss of an expectant category of casualty.[44] The term expectant still exists in training manuals.[45] However, it is, for all intents and purposes, non-existent in the practice of casualty management. While many military care providers with whom I have spoken share similar stories, I rely on evidence provided to me by an Air Force Critical Care nurse to illustrate my point. She says:

> I trained for mass casualty scenarios in which I practiced battlefield triage exercises. One of these exercise scenarios was developed to allow an injured warfighter to be placed in the expectant category to die…part of the evaluation during the exercise was to see if clinicians would place injured warfighters into the appropriate triage category…The actor playing the injured warfighter

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was told it is assumed in the word "expectant casualty." As I establish in this section, that category of casualty is no longer practically in play.

41. *Combat Casualty Care Research Program (CCCRP)*, U.S. ARMY MED. RES. & DEV. COMMAND (June 2019), https://mrdc.amedd.army.mil/index.cfm/program_areas/medical_re search_and_development/ccc_overview.

42. Charles Bausman, *Leave No Man Behind: Implications, Criticisms, and Rationale*, MOUNTAIN TACTICAL INST. (Sept. 2016), https://mtntactical.com/knowledge/leave-no-man-be hind-implications-criticisms-rationale/.

43. *See generally* WOOL, *supra* note 39, at 97–103.

44. *See generally* MAYHEW, *supra* note 27, at intro.

45. *See generally* JESCHKE & HUFFMAN, *supra* note 28, at 72–73 (2019) (discussing a military professional's experience).

scripted to die, was mistakenly triaged into the immediate category…Operating as part of the immediate team…I fixated on saving his life using all the best practices medicine afforded me through higher education and training. Eventually, after doing everything medically possible to save his life the warfighter was pronounced dead. After the exercise ended, I discovered the actor was mis-triaged and was supposed to go to the expectant team. I quickly realized that I would be validated for providing heroic medical interventions because I was given an award for my performance in this exercise even though I failed to achieve the lesson…The real lesson I learned…was that it is not acceptable to have an expectant triage category …Death in the form of an expectant casualty became a medical fiction during my deployments to Iraq and Afghanistan…In practice, the expectant triage category ceased to exist…[all causalities were managed] with maximum personnel, technical, and aero evacuation support.[46]

Without an expectant category of casualty, the COIN paradigm has set up a patient-centered approach to trauma care in the operational context that seeks to avoid death at all costs and discounts it as an "unrealistic, unfair, and un-professional" outcome.[47] As such, this challenge has set up expectations for individuals (care provider and service member), the military organization, and the civilian society.

    1.   Individual Expectations

When thinking about the loss of an expectant category at the individual level, expectations are created in both the individual military care-provider and the injured service member. These expectations establish a unique bond between both parties that creates a focus grounded on the provision of life-saving medical interventions not mission focus. The individual care provider is currently trained to embody a heroic identity of combat lifesaver that will do anything and everything to save an injured service member regardless of cost in resources or capability. To illustrate my point, I provide a concrete example from the first time I presented on this topic at Fort Leavenworth. In suggesting that the word "death" should be integrated into combat casualty care training manuals, a military care provider strongly asserted that he "did not deal in death. Death was the domain of chaplains and mortuary affairs."

In contrast, service members expect that medical resources will always be present and that military care providers will provide life-saving interventions to all catastrophically injured service members. At the same conference, an infantry officer told me that death was not a concern for his service members because medical resources could and would be provided to the most extreme casualties ensuring that all injured warfighters would be saved. As he put it, "Only the enemy dies!" These may seem like extreme scenarios to my readers, as they

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46.  *Id.*

47.  Hetzler, *supra* note 35, at 123.

were shocking to me as a civilian researcher when I first encountered them. However, through many conversations over the course of the last two years, I have come to realize that these are commonly held expectations that are enabled by the loss of the expectant casualty category.

Similarly, the individual morale and willingness of the service member to fight are linked to life-saving casualty management. As General Peter Chiarelli, the Army's former vice chief of staff, said when discussing the importance of patient-centered care that provides the highest level of medical intervention to catastrophically injured service members on the battlefield: "I know if I am providing the kind of combat casualty care that the [warfighter] expect[s] on a battlefield, every single one of them is going to be so much more [of] a soldier that is able to accomplish their mission than they would be if I did not."[48] Said differently, life-saving interventions are seen to motivate service members to take on the danger of the battlefield knowing that they will not need to face the risk of death. As such, military care providers conserve the fighting force by ensuring morale and motivation to fight.

### 2. Military Organizational Expectations

General Chiarelli's comment hints at how loss of the expectant casualty category also creates expectations for the military organization. In order to uphold the patient-centered casualty management that does not acknowledge an expectant casualty category, military leaders have expended tremendous resources to support the world's most advanced trauma care system. As such, the DHA is the third largest source of military spending, averaging over fifty billion dollars a year.[49] Consequently, the military organization expects that constructing a patient-centered trauma care system through development of advanced medical and technological capability will enable the military care provider to prevent death on any type of battlefield without reference to the operational context of the battlefield. Similarly, there is a military organizational expectation that military care providers are trained to negotiate any battlefield on medical expertise alone without involvement in operational and tactical level training.

Such expectations have been set up in the military organization because medical assets have always been available in the COIN paradigm and catastrophically injured service members have received the highest level of medical care without consideration of resources. Furthermore, these organizational expectations have set up a reality where the measure for success

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48. DONALD BERWICK ET AL., NAT'L ACADS. OF SCI., ENG'G, & MED., A NATIONAL TRAUMA CARE SYSTEM: INTEGRATING MILITARY AND CIVILIAN SYSTEMS TO ACHIEVE ZERO PREVENTABLE DEATHS AFTER INJURY 235 (2016).

49. CONG. RESEARCH SERV., FY 2020 BUDGET REQUEST FOR THE MILITARY HEALTH SYSTEM 1 (2019).

of any given battle is determined by out-of-theater survival rates. Consequently, death is seen as failure and mission success is associated with "zero deaths" to such an extent that mission effectiveness is overshadowed by this expectation.[50] In other words, the loss of an expectant casualty category has enabled the creation of a casualty-averse military culture wherein force health and protection is singularly focused on avoiding death at all costs.

### 3.   Civilian Society Expectations

Casualty aversion in the military organization and civilian society is a highly debated topic. While it is not my goal to jump into this debate, I believe this academic conversation illustrates that the military organization and civilian society are in a mutually reinforcing relationship that is not dissimilar to the relationship between the individual military care provider and the service member. Consequently, literature on casualty aversion in military and civilian society affirm that death despair implicit in the COIN paradigm also creates certain expectations in the civilian society. [51] For instance, if a family member serves in the military and is injured, there is a strong expectation that everything will be done to save the family member. If the service member is dying, there is an expectation that the family will be transported to the bedside to say final goodbyes. Finally, if death does occur, there is an expectation that the body will be immediately returned home.

More concerning to me when thinking about the loss of the expectant casualty category is that death despair creates an expectation that civilian society can be disengaged from the broader conflicts in which the military engages. The privilege of being able to disconnect from broader national security concerns produces an expectation that armed conflict comes without cost to civilian society.[52] This disconnect not only creates a civilian society that is less attendant to geo-political concerns that impact national security, but also one that does not participate in the suffering work that is thrust on the few who serve in the military. In other words, civilians are given what Joan Tronto calls a "responsibility pass" from being held accountable for the work in which the military organization engages.[53] As a result, the collective and individual suffering of those in the military is hidden from view as are the enormous short and long-term economic costs of health care allocation.[54]

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50.   Lacquement Jr., *supra* note 11, at 44.

51.   *See* Palazzo, *supra* note 12, at 66; Jonathan D. Caverley, *The Myth of Military Myopia: Democracy, Small Wars, and Vietnam*, 34 INT'L SEC. 119, 156 (2010); Lacquement Jr., *supra* note 11, at 43.

52.   Lacquement Jr., *supra* note 11, at 42–43, 52–53.

53.   JOAN C. TRONTO, CARING DEMOCRACY: MARKETS, EQUALITY, AND JUSTICE 169–177 (2013).

54*.   See generally Costs of War*, BROWN U., https://watson.brown.edu/costsofwar/costs/eco nomic/budget/veterans (last updated Feb. 2015). Since I am not an economic expert, I do not

As Willie James Jennings argues in his essay "War Bodies: Remembering Bodies in a Time of War," civilians engage the military organization from an abstract distance that reinforces a growing chasm between the service member and the society served.[55] He says that the civilian society functions by ignoring the impact of armed conflict through the institutional mechanism of death despair.[56] This mechanism allows citizens to remain numb to the reality of what it means to kill and be killed.[57] As one service member said to me: "The civilian society heroizes us for going into harm's way for our country but dying—the thing that used to make us noble—is the very thing we are not allowed to do." Furthermore, the pain and suffering that comes with catastrophic battlefield injury disappears from the collective civilian social consciousness.[58] In response, civilian society glosses over the military organization and individual service members with a dedication to a form of hyper-patriotism that is obsessed with the wounded or heroic service member.[59]

## B.   LSCO Paradigm: Reserve Triage

Having discussed some of the expectations—individual, military organization, and civilian society—that are established by the loss of an expectant category of casualty in the COIN paradigm, I want to briefly explore how these expectations might be problematic when considering the reality of LSCO on a multi-domain battlefield. As stated in the introduction, military medical experts are projecting an entirely different mass casualty scenario. A mass casualty is defined in a medical situation as occurring when the number and severity of casualties overwhelm the available resources.[60] It is not that mass casualties did not exist in COIN. However, the military context was defined by

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directly address the enormous monetary cost associated with the human carnage that has occurred in Iraq and Afghanistan. Projections have indicated that the long-term cost of care for disabled veterans is in excess of $600 billion. This is supported by Linda Bilmes' and Joseph Stiglitz's work *The Three Trillion Dollar War*, which was published in 2008. Since then, this estimate has been surpassed, and Linda Bilmes has suggested the cost of care for veterans is as high as $1 trillion. Linda J. Bilmes, *Current and Protected Future Costs of Caring for Veterans of the Iraq and Afghanistan Wars* 1 (Harv. Kennedy Sch. Mossavar-Rahmani Ctr. for Bus. & Gov't, Working Paper No. 2011-06, 2011). My simple point is that there are heavy economic costs to death despair that have not been evaluated in the short-term allocation of medical resources or the long-term allocation of resources for health care. More importantly, these costs are hidden from immediate view and discussion in the civilian society.

55.  Willie James Jennings, *War Bodies: Remembering Bodies in a Time of War*, *in* POST-TRAUMATIC PUBLIC THEOLOGY 23–25 (Stephanie N. Arel et al. eds., 2016).

56. *See generally id.* at 23–28.

57. *Id.*

58. *See* MAYHEW, *supra* note 27, at intro. *See also* WOOL, *supra* note 39, at 97–103.

59. *See* Jennings, *supra* note 55, at 21.

60.  WHO, MASS CASUALTY MANAGEMENT SYSTEMS 6 (2007), https://www.who.int/hac/techguidance/MCM_inside_Jul07.pdf.

a resource rich environment. In contrast, LSCO will be defined by a resource constrained environment whereby the volume of casualties will increase while the amount of medical resources will decrease.

Preparing for large-scale casualty estimates, lack of air superiority, limited or no casualty evacuation, and complicated civil–military interaction is necessary in the face of LSCO.[61] Expected systematic denial of services means limitations in resupply, communication, control, and continuity of care.[62] Intangible effects of legal, social, financial, and media warfare will further complicate actions. Although absent in combat operations for almost a century, nonpermissive environments and uncontrolled engagements will have affects that cannot be denied.[63] The medical reality of such an operational environment will be that military care providers will have scarce resources far forward on the battlefield, no medical infrastructure in country, and limited to no casualty evacuation.[64] As such, the continuity of care that enabled the COIN paradigm will not exist in LSCO making it impossible to medically stabilize and maintain catastrophically injured service members.[65] Furthermore, it is likely that tactical necessity will restrict medical access, govern distribution of scarce medical resources, and compel reverse triage.[66] Under these circumstances, not only will catastrophically injured service members die, but there will also a thousand-fold increase in the number of causalities that must be attended to in a LSCO paradigm.[67]

When thinking about a LSCO paradigm, the expectant casualty category cannot be hidden behind medical technology and infrastructure. It will not only be a ubiquitous reality, but it will also guide military care providers' medical decision-making. In other words, military care providers will be forced to shift their medical decision-making from a singular focus on life-saving care to triage. The latter form of decision-making includes an assessment not only of who will live, but also who will die, and implies some form of death-care. "Having forged an expectation that life-saving medical care" can and "will be provided to all" injured service members, "failure to provide medical care is likely to provoke fear" in individuals (service members and military care providers), "the military organization, and civilian society alike even if it is militarily necessary."[68]

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61. *See* Perkins, *Preparing for the Fight Tonight*, *supra* note 13, at 6–12.

62. *See* JESCHKE & HUFFMAN, *supra* note 28, at 76.

63. Michael Lundy et al., *Feeding the Forge: Sustaining Large-Scale Combat Operations*, U.S. ARMY (July 18, 2019), https://www.army.mil/article/223833/feeding_the_forge_sustaining_ large_scale_combat_operations.

64. Hetzler, *supra* note 35, at 123.

65. *Id.*

66. *Id.* at 123–124.

67. JESCHKE & HUFFMAN, *supra* note 28, at 76.

68. *Id.* at 69.

### 1.   Shifting Expectations from COIN to LSCO: Individual

The loss of the expectant category of casualty is an enormous challenge at the individual level when thinking about the nature of LSCO. If at least two generations of service member have become habituated to the idea that they are inoculated against death with the help of life-saving casualty management—as it seems they are—then countering death despair will likely provoke extreme fear in both the military care provider and service member alike making them both combat ineffective if these expectations are not shifted.[69]

Expectations that gave rise to the loss of an expectant casualty category have also given rise to a loss of medical decision-making that focuses on mission over individual—a skill that will be necessary to perform operational triage in LSCO.[70] Shifting expectations in the individual military care provider presents at least two obstacles. First, when life-saving care is provided regardless of the condition of catastrophic injury, the military care provider's ability to discern medical futility atrophies.[71] The cognitive ability to assess futility is a necessary component of effective triage.[72] Second, having forged a military identity in care providers that is defined by life-saving skills, accepting death as a realistic outcome of catastrophic injury places the identity of the military care provider at risk.[73] In other words, the damage control paradigm has habituated military care providers not only to see themselves as lifesavers, but in so doing, to also instinctually respond to the level of damage to the service member's body without thought for the military mission. If these expectations are not shifted, the ability of the care provider to place the mission above the injured service member will be compromised and could put the mission at risk.

Similarly, if individual service members are expecting that military care providers can and will do everything in the face of catastrophic injury, they may not be able to face the extreme reality of mass casualties in LSCO, which would greatly impede the performance of individual service members. Recently, I was discussing the topic of death despair with an infantry officer. He was intrigued and believed that any discussion of death would hinder the morale of his company. In justifying his position, the officer told me two separate stories. First, he explained that he had constructed a standard operating procedure (SOP) for his company to use in Afghanistan. Chapter Nine of this SOP was dedicated to defining the procedures necessary for dealing with a fatal casualty. When he handed out the manual to those service members under his command, the officer excluded Chapter Nine on the notion that it would distract from the fight. In illustrating the importance of avoiding any focus on death, this officer provided

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69.   *See generally id.* at 72–76.
70.   JESCHKE & HUFFMAN, *supra* note 28, at 75–76.
71.   *Id.* at 75.
72.   Falzone et al., *supra* note 27, at 43–44.
73.   JESCHKE & HUFFMAN, *supra* note 28, at 75.

an example. He explained that in training exercises, one young service member became distracted by every casualty. In response to a casualty, the service member would stop and attend to the casualty instead of returning fire, which caused five other service members to eventually "die" in the training exercise. The officer thought the training outcome was the result of service member's focus on injury, which would be worse if this service member had been explicitly trained to prepare for death. My interpretation of this scenario was not that introducing the possibility of death distracts, but that death despair distracts. In other words, the young service member's lack of familiarity with death caused him to be distracted and attend to the injured service member and not the fight in which he was engaged. Placing the mission over the life of a fellow injured service member is something that must be trained for and integrated into the decision-making capacity of the soldier. As such, both military and medical decision-making need to include the reality of death and dying at the individual level in order to shift to the appropriate type of decision-making that will support mission success in the face of mass casualties on a multi-domain battlefield.

### 2. Shifting Expectations from COIN to LSCO: Military Organization

The previous illustration is interconnected with the challenge of shifting expectations at the military organization level. In arguing that the military organizational culture is casualty averse, Richard Lacquement's provides a concrete example illustrating how death despair can impact mission success.[74] He says that: "An important cost of this approach was the failure to capture or destroy large numbers of al-Qa'ida and Taliban forces—and possibly Osama Bin Laden himself—during the Tora Bora fight of December 2001."[75] More noteworthy is that Lacquement argues that this death despair is a life-force that manifests not only in casualty aversion but also risk aversion across the entire military organization.[76] He presents the idea that force protection not mission success has become the military's priority.[77] Relying on Brigadier General Daniel Kaufman, Lacquement suggests that officers do not have the ability to exercise judgement that takes into consideration the context of the battlefield and act in accordance with the mission.[78] Acceptance of injury has become conflated with recklessly putting service members in harm's way.[79] Such a conflation also confuses the strategic implications of catastrophic injury with the tactical implications of catastrophic injury. Said differently, when those engaged in the fight are worried about the political implications of service members'

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74. Lacquement Jr., *supra* note 11, at 45.
75. *Id.*
76. *Id.* at 46.
77. *Id.* at 47.
78. *Id.* at 46.
79. Lacquement Jr., *supra* note 11, at 47.

dying their decision-making is hampered by not prioritizing the immediate needs of the mission. When a military organization becomes sheepish about harm to individual service members and unwilling to accept catastrophic injury, a risk-averse military culture is fostered.[80] Within such a culture, death despair causes service members at all ranks across the organization to ignore the reality that harm is implicit in the nature of military operations.[81]

When considering the mass casualty scenarios projected in LSCO, the military organization would collapse if it remained focused on individual catastrophic injury and hesitated to respond in accordance with the mission's objectives.[82] The resources demanded by the COIN paradigm will not only be absent, but the entire logistical structure of the U.S. military will be ill-prepared for the reality of mass casualties.[83] Consider, for instance, the removal of bodies from the battlefield alone. If there is no casualty evacuation there will also be no infrastructure to remove dead or catastrophically injured service members from the battlefield. Furthermore, there is no longer a grave's registration system large enough to support the needs of extreme mass casualty scenarios.[84] As such, if expectations created by death despair across the military organization are not shifted, it will be hard to plan for the logistical and strategic implications of mass casualties other than in the abstract, which could greatly impact the ability of the military to fight as well as societal support for combat operations.

### 3. Shifting Expectations from COIN to LSCO: Civilian Society

At a civilian level, death despair has hidden the reality of catastrophically-injured service members from view. The expectations that come with the loss of an expectant casualty category means that the civilian society does not to participate in suffering that is inherent in armed conflict. Moreover, the civilian society does not participate in the day-to-day healing from the experiences of armed conflict. The collective social responsibility for military engagement becomes a free-floating form of responsibility that is expressed in a public performance of a patriotic master narrative that does not attend to the day to day experience of returning injured service members or military care providers. In this political narrative, civilian society supports service members through appreciation and concern for the painful work that is performed by those who have deployed in support of our national security interests. However, this pathos-inducing narrative thwarts the grief and healing work of individual service members as they attempt to make meaning from their military

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80. *Id.*

81. *Id.* at 45–47.

82. *See generally id.* at 47.

83. *See generally* JESCHKE & HUFFMAN, *supra* note 28, at 74.

84. MICHAEL SLEDGE, SOLDIER DEAD: HOW WE RECOVER, IDENTIFY, BURY, AND HONOR OUR MILITARY FALLEN 60 (2005).

experiences.[85] Meaning is provided by the national identity that has been inscribed through the valorization of a wounded warrior or the heroic military care provider, not the nuanced and complex layers of pain that must be processed when dealing with the rehabilitation and reintegration process.[86]

If the expectations that have engendered a civilian society with lack of awareness of the military organization and individual service member are not addressed, the lack of public support for any engagement in LSCO could be undermined. Even if the public were to support involvement in LSCO with a near-peer enemy, the expectations of being flown to the bedside for final goodbyes or having the body returned stateside would be sharp blows to the collective consciousness of the civilian society. The numbness that is induced by death despair would likely invoke deep social melancholia when confronted with mass casualty scenarios that could create further divisions between the individual service members, the military organization, and the civilian society they serve in support of national security.

### 4.  Diagram of Broad Scope of Challenges

As you are starting to see, the complex challenge of shifting expectations around death and dying is a behemoth. In order to give shape to my thoughts, I constructed a visual diagram that outlines various aspects of what needs to be identified and articulated in order to begin the project of building a more comprehensive conceptual map that can manage the organizational change that comes with shifting expectations.

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85.  Jennings, *supra* note 55, at 23, 25–26.

86*.  See* MAYHEW, *supra* note 27, at 139. *See also* WOOL, *supra* note 39, at 99–130. *See generally* Corey S. Powell, *War Without Death*, DISCOVER MAG. (Apr. 1, 1999), https://www.dis covermagazine.com/technology/war-without-death (discussing newer inventions in nonlethal weaponry).

Diagram One

| CASUALTY MANAGEMENT SHIFTING EXPECTATIONS ABOUT DEATH AND DYING BROAD SPECTRUM OF CHALLENGES | | | | | |
|---|---|---|---|---|---|
| PRE-DEPLOYMENT (*ad-Bellum*) Readiness | | DEPLOYMENT (*in-Bellum*) Clinical Practice Guidelines | | POST-DEPLOYMENT (*post-Bellum*) Retention, Resilience, Reintegration | |
| COIN | LSCO | COIN | LSCO | COIN | LSCO |
| INDIVIDUAL | INDIVIDUAL | INDVIDUAL | INDIVIDUAL | INDVIDUAL | INDIVIDUAL |
| MILITARY | MILITARY | MILITARY | MILITARY | MILITARY | MILITARY |
| SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY |
| INDVIDUAL | INDVIDUAL | INDVIDUAL | INDVIDUAL | INDVIDUAL | INDIVIDUAL |
| MILITARY | MILITARY | MILITARY | MILITARY | MILITARY | MILITARY |
| SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY |
| INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL |
| MILITARY | MILITARY | MILITARY | MILITARY | MILITARY | MILITARY |
| SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY |
| INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL | INDIVIDUAL |
| MILITARY | MILITARY | MILITARY | MILITARY | MILITARY | MILITARY |
| SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY | SOCIETY |

The leftmost column of each block is labeled vertically: CHALLENGE

The diagram includes the entire deployment cycle. To indicate that there are ethical and practical expectations attendant to each phase of deployment, I have included terminology from both the just war tradition and force health protection. Each dark black rectangle represents one broad challenge that has multiple attendant expectations that will need to be identified and articulated for the individual, military, and society both COIN and LSCO. Thick solid black lines outlining broad challenges symbolize the idea that the challenge has not been articulated. Dotted lines symbolize the idea that the phases of expectation naturally influence each other. Smaller rectangles inside the challenge represent expectations that need to be identified. Those that appear in shades of grey represent implicit expectations that have been formed by the COIN paradigm. Those that appear in white represent a new LSCO paradigm. Thin solid lines separating COIN from LSCO symbolize the idea that there is currently no articulated means of managing a shift in expectation from COIN to LSCO so there can be no influence between the two categories of expectation. Once the component parts of the diagram begin to be filled, this information can serve as the basis from which to develop training to manage the shift from medical decision-making in COIN to LSCO.

This diagram can also serve as a starting point for outlining research that aims to develop a comprehensive conceptual map managing strategic organizational change around death despair. In order to specify what type of research is needed to fill out the component parts, I turn next to discuss why it is important that academic experts in anthropology, history, and political science lead interdisciplinary teams who collaborate with military medical and strategic experts.

## III. DAMAGE CONTROL INTERDISCIPLINARITY: WORKING WITH DEATH DESPAIR

Having established that death despair is implicitly woven into the expectations that ground medical decision-making in the COIN paradigm, the question is now how to construct a comprehensive conceptual map for managing expectations that need to shift around death and dying to prepare for a LSCO paradigm. In justifying the importance of academic interdisciplinary teams that are external to the military organization but intimately collaborate with military medical and strategic experts, I turn to literature in organizational behavior. This research highlights why it is important to strategically think about shifting expectations as a second-order organizational change. Thereafter, I suggest why external, interdisciplinary academic teams need to lead the research process. Finally, I highlight which aspects of the research will be assigned to each party in the interdisciplinary team.

While these insights might seem obvious to you, as they did to me, I have come to learn that it is not without contention that academics engage in applied

policy and program development.[87] In contrast, it is not without contention that academic outsiders are viewed as ineffective when attempting to use highly specialized research methodologies to inform national security policy.[88] My basic point in this section is that different groups of academics have theoretical expertise while certain other groups of professionals have practical expertise. Both theoretical and practical wisdom are necessary in creating a rich base of evidence from which effective and informed training and policy can be developed. In this section, I show how the academic and practical worlds of knowledge should work together in specific ways to resolve the complex challenge of death despair that confronts national security. To establish this point, I turn to explain why it is important that external academics lead such research.

## A. *Strategic Organizational Change: Systems Theory and Groupthink*

Systems theory research seeks to understand how organizations interact with the environment in which they operate.[89] To do so, this theory researches organizations as systems that function like living organisms.[90] Large organizations, such as the military, are composed of complex layers of subsystems. One example is military medicine. These subsystems coordinate well with each and the larger organization enabling optimal performance due to cognitive schema that provide both shared meaning and frames of reference for tasks.[91] Cognitive schemata are developed over time through individual and group choices that are motivated by the larger organizational mission.[92] The construction of cognitive schema comes through first-order organizational change allows for consistency, continuity, and cohesion of organizational behavior by providing an implicit framework of meaning against which individuals within an organizational subsystem orient their action toward a

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87. MICHAEL C. DESCH, CULT OF THE IRRELEVANT: THE WANING INFLUENCE OF SOCIAL SCIENCE ON NATIONAL SECURITY 2 (2019).

88. *See* Paul C. Avey & Michael C. Desch, *What Do Policymakers Want from Us? Results of a Survey of Current and Former Senior National Security Decision Makers*, 58 INT'L STUD. Q. 227, 243–45 (2014).

89. *See* Charissa P. Cordon, *System Theories: An Overview of Various System Theories and Its Application in Healthcare*, 2 AM. J. SYS. SCI. 13, 14 (2013).

90. Cornell C. Chikere & Jude Nwoka, *The Systems Theory of Management in Modern Day Organizations: A Study of Aldgate Congress Resort Limited Port Harcourt*, 5 INT'L J. SCI. & RES. PUBLICATIONS 1, 1 (2015); Cordon, *supra* note 89, at 16–19; Francis Amagoh, *Perspectives on Organizational Change: Systems and Complexity Theories*, 13 INNOVATION J.: PUB. SECTOR INNOVATION J. 1, 2–3 (2008).

91. *See* Jean M. Bartunek & Michael K. Moch, *First-Order, Second-Order, and Third-Order Change and Organization Development Interventions: A Cognitive Approach*, 23 J. APPLIED BEHAV. SCI. 483, 485–86 (1987).

92. *Id.* at 484–86.

common interpretation of and response to shared events.[93] As such, first-order change forms an implicit web of meaning relative to cultural norms, practices, judgements, and values of the organization.[94] In achieving effective organizational performance, first-order change is meant to tacitly reinforce the present state of organizational behavior through reinforcement of implicit organizational culture.[95] As such, first-order change developed a military organizational system and medical subsystem that are inherently saturated in death despair. More specifically, first-order change enabled the development of the COIN paradigm which implicitly orients medical decision-making exclusively around life-saving interventions.

As mentioned in my introduction, major shifts are occurring in military medicine. Along with the shift in types of future conflicts, DHA is changing how medicine is performed both in the deployment and garrison environments.[96] These major changes create an inherently unstable situation as periods of transition are inherently volatile. Major shifts in a subsystem, if poorly managed, cause disruption across the entire organization because the larger organization self-regulates to maintain the status quo causing organizational friction and eventual break down. Consequently, unmanaged organizational change causes severe unintentional consequences that negatively impact the performance of individuals and the entire organization.[97] For this reason, second-order change management focuses on strategically shifting organizational behavior by attempting to modify the present cognitive schema toward a new strategic goal.[98] Second-order change management achieves two tasks: first, excavating the meanings implicit in cognitive schemas, and second, articulating new strategic goals against which change is directed.[99] Third-order change is the actual development and implementation of training based on strategic planning that occurs in the second-order change management process.[100] The goal of such training is two-fold. First, to make individuals aware of the present schema regulating their actions.[101] Second, to provide pathways that expand the original cognitive schema to support new interpretations of and responses to events that

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93. *Id.* at 484.

94. *Id.* at 485–86.

95. *Id.* at 486.

96. *See* Quay Drawdy, *Changes Coming to a Medical Group Near You*, MAXWELL AIR FORCE BASE (April 15, 2019), https://www.maxwell.af.mil/News/Display/Article/1814702/changes-com ing-to-a-medical-group-near-you/.

97. *See generally* Sunday Abayomi Adebisi et al., *System Theory and Effective Performance in a Changing Environment: A Post-Mortem Study of Nigeria Public Establishment*, 6 UNILAG J. HUMAN. 77–99 (2018).

98. Bartunek & Moch, *supra* note 91, at 486.

99. *See id.* at 486–88, 495.

100. *See id.* at 486.

101. *See id.* at 488.

support the expanded organizational mission.[102] Obviously, in this article the topic of concern is enhancing cognitive schema to include death and dying as a medical reality of LSCO.

When considering who is best suited to lead an interdisciplinary research team that develops a comprehensive conceptual map of second-order change management that lays the foundation for third-order organizational change, it might seem natural to suggest that those most experienced in the subsystem or the larger organization ought to be at the helm, i.e. military strategic or medical experts. However, the difficulty of successfully implementing radical strategic change in any organization using professionals who are internal to a system or subsystem, is that those who are familiar with the current organizational behavior tend toward the following three behaviors: defensiveness,[103] groupthink,[104] and strategic drift.[105] These behaviors reinforce the current cognitive schemas and organizational behavior.[106] Furthermore, it is difficult for those within an organization to speak truth to power when it comes to necessary change because their jobs are dependent on the approval of their superiors.[107] This is amplified in a military organization where rank structure implies certain levels of organizational power. The practical result of these factors is that when those internal to an organization attempt to lead its strategic change, the output of the research becomes reproduction of the old organizational cognitive schemas and practices.[108]

Therefore, I have suggested that the interdisciplinary team be led by external academic experts who intimately collaborate with military medical and strategic experts to reduce the likelihood of reproduction of the same organizational behavior. Academic experts from different disciplines will reduce the likelihood of groupthink because each discipline is formed according to a different set of

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102. *See id.* at 495–96.

103. *See* CHRIS ARGYRIS, STRATEGY, CHANGE AND DEFENSIVE ROUTINES 5–6 (1985).

104. *See* IRVING L. JANIS, GROUPTHINK: PSYCHOLOGICAL STUDIES OF POLICY DECISIONS AND FIASCOES 7–10 (2d ed. 1982).

105. *See* GERRY JOHNSON, STRATEGIC CHANGE AND THE MANAGEMENT PROCESS 244–47 (1987).

106. *See* A.B. (Rami) Shani & Jean-Francois Coget, *Instructor's Manual: Behavior in Organizations: An Experimental Approach*, CAL. POLYTECHNIC ST. U.*,* https://www.cob.calpoly. edu/behavior-in-organizations/wp-content/uploads/sites/12/2017/06/Instructor-manual.pdf (last visited Jan. 5, 2020). *See also* Maria R. Shirey, *Group Think, Organizational Strategy, and Change*, 42 J. NURSING ADMIN. 67, 67–69 (2012); Tanya Sammut-Bonnici, *Strategic Drift*, RESEARCHGATE (Oct. 30, 2017), https://www.researchgate.net/publication/272184191_Strategic _Drift.

107. *See generally* James R. Detert, *Cultivating Everyday Courage*, 2018 HARV. BUS. REV. 128–135.

108. *See generally* Paul Schoemaker, *Why Thinking Outside-In Is Your Key to Success*, INC. (Dec. 19, 2017), https://www.inc.com/paul-schoemaker/why-outside-in-thinking-is-your-key-to-success.html.

epistemological assumptions about research and valid formulation of knowledge.[109] In other words, each discipline is based on a worldview different from each other and the military organization. Additionally, external experts will be more resistant to the influence of power structures implicit in the military organizational hierarchy. Academic experts from multiple disciplines will enter the research project not only with different grounding assumptions relative to their specialized research method, but also different tools to achieve the task at hand. As such, having the research team led by external academics will not only help mitigate the opportunity for self-referential outcomes, but also provide a more comprehensive conceptual map.

## B.   *Interdisciplinary Team Composition*

The aims that ground interdisciplinary research on second-order organizational change will focus on describing the following: how death despair is operant in the current COIN casualty management paradigm, what the nature of catastrophic injury will be on the future multi-domain battlefield, and how mass casualty scenarios will impact mission effectiveness in LSCO. To complete this comprehensive conceptual map, three academic disciplines and two groups of military experts should compose the interdisciplinary team. The tools necessary to perform the two aims can be found in the academic disciplines of anthropology, history, and political science. The third is best achieved by integrating military medical and strategic experts.

## C.   *External Academic Leads: Anthropology, History, and Political Science*

To place these tasks on my visual diagram, I turn first to the grey rectangles at the individual and military organizational level. When thinking about the current expectations established in COIN casualty management, applied anthropology serves as the best research discipline to complete these boxes. Academic anthropology has a checkered when considering this disciplines involvement in policy science and national security. It can boast of both noteworthy successes and failures. Currently, academic anthropology is hesitant to engage in applied work because it moves beyond the theoretical purity of the discipline especially in relationship to questions of national security.[110] Interestingly, corporations have begun to see the valuable asset applied anthropology brings to corporate success.[111] Anthropologists help corporate

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109.   Machiel Keestra, *Metacognition and Reflection by Interdisciplinary Experts: Insights from Cognitive Science and Philosophy*, 35 ISSUES INTERDISC. STUD. 121, 124, 148 (2017).

110.   *See* Thomas Weaver, *Anthropology as a Policy Science: Part I, A Critique*, 44 HUM. ORG. 97, 101 (1985).

111.   *See also Corporate Anthropology: Michael Henderson at TEDxAuckland*, TEDXAUCKLAND (2009), https://tedxauckland.com/people/michael-henderson/. *See generally*

executives better understand both the end-users of their product or service and create meaningful corporate policy by understanding corporate culture from a bottom-up manner.[112] Developing corporate culture and policy that are informed by those at the ground level has proven effective in increasing both job performance and better corporate outcomes.[113]

Applied anthropology brings tools to excavate beliefs, assumptions, practices, symbols, meanings, and interactions implicit in any given organizational culture.[114] Moreover, this discipline provides various modes of analysis that can shine light on how specific subcultures interact to form implicit cognitive schema that operate within an overarching organizational culture in subsystems.[115] As Jarrett Zigon points out, anthropology critically evaluates the ordinary practices to understand how these practices form and are formed by political agendas attendant to a particular organizational culture by looking for embedded categories where tactic agreement exist and give implicit meaning to notions of: "intention, responsibility, and reasons for action; the exercise of practical judgement; the forms of sustained attention and labor subsumed under the concept or practice of 'care.'"[116] Therefore, anthropology is suited not only to reveal the cultural genealogy of implicit cognitive schema around death despair in the COIN paradigm, but also to "reveal their potentially (not so) hidden political-economic implications."[117] Because the discipline is interested in humans and human interaction, anthropology will also be critical to negotiations among various different stakeholders and the agenda of an interdisciplinary research team.

Next, I turn to the white rectangles at the individual and military organizational level. When thinking about a new LSCO paradigm, history serves as the best academic discipline to identify and articulate which battlefields of the past produced extreme mass casualty scenarios akin to those scenarios being discussed in LSCO. Again, academic historians debate whether or not history should be applied to the future in order to learn lessons from the past. Unlike anthropology, the use of applied history to national security concerns is not a novel concept. Lacquement carefully articulates the important role history plays

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Mike Walsh, *The CEOs of the Future Will Need to be Anthropologists, as well as Technologists*, YOUTUBE (June 23, 2013), https://www.youtube.com/watch?v=hALidEdpdMM.

112. *Id.*

113. *See generally Corporate Anthropology: Michael Henderson at TEDxAuckland supra* note 111.

114. *See id.*

115. *See id.*; Taysir M. Khatib, Organizational Culture, Subcultures, and Organizational Commitment (1996) (published Ph.D. dissertation, Iowa State University).

116. Jarrett Zigon, *An Ethics of Dwelling and a Politics of World-Building: A Critical Response to Ordinary Ethics*, 20 J. ROYAL ANTHROPOLOGICAL INST. 746, 747–750 (2014).

117. *Id.* at 747.

in analogic reasoning.[118] In arguing that historical cases can provide a useful foundation for helping identify and articulate national security concerns, Lacquement suggests that historical data help to establish general patterns that aid in clarifying future contexts.[119] This contextual information can help military strategists to hypothesize about subsequent choices. However, Lacquement also clearly articulates the limits of historical case analysis when preparing for future national security concerns.[120] He says that history ought not to be seen as a comprehensive guide to predict future action.[121] He warns that it is important to be nuanced in the application of historical cases to future context because there will be many important differences between the past and the future.[122] Being overly literal in the application of historical data to future scenarios could be detrimental to the actual overall objective of training good decision-making. As Lacquement points out, military strategists have, at times, had the tendency to use historical analysis as a way to control the future.[123]

Historical cases used as analogs to a LSCO multi-domain battlefield work well for this project because the conceptual map needs to be comprehensive, not an exact or literal replication. As you will recall, the interdisciplinary map is serving as the foundation for a metaphorical damage control manual that will guide training and policy. Academic historians are nuanced in their thinking through case analysis. Therefore, they are essential in helping articulate limits of understanding when extrapolating future commonalities from historical cases. For this reason, I suggest that academic historians engage in excavating the various historical cases before military medical and strategic experts enter the conversation. Moreover, Lacquement points out that historical cases, when appropriately used in training, serve as a useful psychological preparation for service members.[124] He says that historical cases allow individuals to confront the unknown by evaluating patterns from the past to hypothesize about various decision-making options and weigh the benefits and burdens of those options.[125] This process enables military decision makers to "develop sound discretionary judgment."[126] As such, the discipline of history is critical not only because it has the tools to access and assess necessary data central to the development of a comprehensive conceptual map, but also because the outputs historians provide are of central concern to this project, namely preparing military care providers for medical decision-making in a LSCO paradigm.

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118. Lacquement Jr., *supra* note 11, at 59.
119. *Id.* at 60–61.
120. *Id.* at 61.
121. *Id.*
122. *Id.*
123. Lacquement Jr., *supra* note 11, at 67.
124. *Id.* at 66.
125. *Id.*
126. *Id.* at 60.

Finally, I turn to the grey and white rectangles at the civilian society level. Deploying military assets to achieve certain political goals requires not only articulating the implications of achieving those goals—mass casualty projections of LSCO—but also understanding the civilian society's readiness and willingness to support those stated political goals. The debate on casualty aversion referenced above suggests that it is unclear whether civilian society would support a higher number of casualties in support of LSCO. Furthermore, it suggests that civilian society's current level of support for military fatality rates is unknown. What is known is that the COIN paradigm has established expectations relative to catastrophic injury that need to be shifted in order to prepare for a LSCO paradigm. I suggest that the best discipline to articulate the civilian society's current and future expectations on death and dying in support of national defense is political science. Since war is one instrument of political power, political science a central discipline in national security studies.[127] More importantly, political science specializes in understanding how political decision-making impacts and is impacted by social expectations.[128]

While political science seems like a natural disciplinary fit for constructing present and future social expectations of relative to catastrophic combat injury, the use of political science for the purposes of polling public opinion is not without contention.[129] At a recent conference on Armed Forces and Society, Timo Graf argued that political science research has not been invested in exploring the public opinion in relationship to the changing security environment with Russia and China.[130] His basic point was that if academics in political science ignore public opinion, then it could thwart the construction of nuanced defense policy, undermine the legitimacy of the military organization, and impede national security.[131] His presentation not only established that the academic discipline has the tools to query, aggregate, articulate and analyze the social expectations both current and future, in expectation on death and dying in relationship to military operations, but also that including the expectations of civilian society when thinking about LSCO is critical.[132]

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127.  *See generally* BERTAND BADIE, INTERNATIONAL ENCYCLOPEDIA OF POLITICAL SCIENCE 2541 (2011).

128.  *See generally* Stuart Soroka & Christopher Wlezien, *Public Opinion and Public Policy*, *in* OXFORD HANDBOOK OF CANADIAN POLITICS 1–4 (John C. Courtney & David E. Smith eds., 2010) (discussing the impacts of public opinion on policies).

129.  Joshua D. Kertzer & Thomas Zeitzoff, *A Bottom-Up Theory of Public Opinion About Foreign Policy*, 61 AM. J. POL. SCI. 543, 554 (2017).

130.  *See generally* Timo Alexander Graf, *Unity in the Face of Threat? Exploring the Empirical Relationship Between Strategic Threat Perceptions and Public Support for a Common European Army in Germany*, 29 EUR. SEC. 55 (2020).

131.  *Id.* at 56.

132.  *See generally id.* at 55–73.

While the more practical applied aspects of public opinion polling may seem messy for the typical political science academic, they are essential to this project because they possess the richest theoretical knowledge on public opinion, representation and willingness to support national and international policy.[133] As such, political scientists have the most refined understanding of how best to assess the civilian society's current and future expectations on death and dying as a result of military operations.

### 1. Military Medical and Strategic Experts

Since academic anthropologists, historians, and political scientists are not necessarily intimately familiar with the details of national security as it relates to medicine on the battlefield, it will be critical that interdisciplinary academics also intimately collaborate with their military counterparts. To do so, the interdisciplinary team will need to heavily rely on military medical and strategic experts at the beginning and end of this process. At the beginning, military medical and strategic experts will be essential to help refine research aims as well as the research process. In the middle, the bulk of the data collection and analysis process will be led and performed by academic experts. At the end, military medical and strategic experts will be essential to the consolidation of data into a comprehensive conceptual map.

What I originally took to be an innocuous proposal, I know realize is a radical idea. The biggest challenge in constructing an interdisciplinary research team to investigate death despair in military medicine may not only be the topic of death, but also disciplinary boundaries that allow academics to remain safe within its specialized notions of academic validity and rigor. Some of the biggest hurdles of interdisciplinary research are terms of art and linguistic tricks that keep academic disciplines pure and focused internally on self-referential work in the academy. While internal coherence is necessary on some level, it can impede participation in the translation and implementation work necessary to construct effective and informed policy and training development.[134] If it is possible to overcome various disciplinary and military skepticism and work together, I believe such an interdisciplinary team could provide an enormously helpful comprehensive conceptual map that illustrates the broad scope of challenges related to shifting expectations from those that exist in the COIN paradigm to those that must exist in a LSCO paradigm. As such, interdisciplinary damage control could serve as an antidote to death despair in military medicine.

### IV. CONCLUSION: DEATH DESPAIR PRESENT AND FUTURE

In this article, I developed a modest argument suggesting that to effectively shift expectations relative to death and dying in casualty management, the DHA

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133. *See generally* Soroka & Wlezien, *supra* note 128, at 2–4.

134. *See* JANIS, *supra* note 104, at 7–9.

needs to support interdisciplinary research that focuses on strategic second-order organizational change before developing health policy and medical training for LSCO. Specifically, I suggested that this interdisciplinary team needs to be led by academic experts in anthropology, history, and political science in collaboration with military medical and strategic experts. In bringing to light the problem of death despair, I hope I have achieved my professional goals of presenting critical questions about the normative focus on life-saving medical interventions in military casualty management. I also hope my argument achieved the task of providing a valuable way to scope to this problem, as well as guided my intended audience to appropriate experts and methods to best research how to shift expectations around death and dying in military medicine.

While it is important to articulate a comprehensive conceptual map that outlines what is needed to address death despair in casualty management, it is not enough to be properly prepared for the future multi-domain battlefield in LSCO. Using this information, third-order organizational change management in the form of military training will need to be developed to properly prepare military care providers for medical decision-making in a LSCO paradigm. As obvious as it may sound, none of this can happen without the support of national and international civilian and military leaders who understand the central role military medicine plays in national security. Until it is made clear how medical decision-making has an incredible impact on the effectiveness of military operations, it will be hard to justify the importance of the research outlined in this article. However, to ignore the importance of this topic, is also to leave our military care providers unprepared to truly conserve the fighting force, which places undue stress on the military organization and puts national security at risk.

You will note that I have not included economists and lawyers in the development of this comprehensive conceptual map. While I believe these disciplines are essential to my broader project of constructing a set of interlocking arguments for why military medicine needs to be at the national and international strategic planning table, they are not central to shifting expectations in medical decision-making—the topic of concern in this article. In the second phase of this project, economists and lawyers will be essential in determining how to conceptually frame the question of how to best conceptualize military and medical resource allocation on the future multi-domain battlefield.

To conclude, I will gesture to why death despair is an important topic to me as an ethicist. Recently, I have started to explore social psychological research on Terror Management Theory. In short, this theory studies death despair through the construct of thanatophobia—the fear of death.[135] The goal is to better understand how human beings react when confronted with human

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135. Psychology Today, *Terror Management Theory*, https://www.psychologytoday.com/us/basics/terror-management-theory (last visited Dec. 31, 2019).

mortality.[136] Empirical evidence strongly suggests that individuals seek to affirm their heroic identity by forming small in-groups that give allegiance to a rigid authoritarian leadership.[137] When thinking about the extreme mass casualty scenarios anticipated in LSCO, I worry that death despair in military medicine creates a situation that is rife for war crimes. This is especially true, when considering the heroic combat life-saver identity that has been forged in our military care providers. If clinicians are unprepared to confront death, it could not only cause operational ineffectiveness, but also a strong desire to reinforce this heroic identity.[138] To avoid rigid adherence to a heroic identity and authoritarian leadership, Terror Management Theory suggests that individuals need to develop a thick relationship with death.[139] Though still inchoate in my thinking, Terror Management Theory suggests to me that shifting expectations in casualty management from death despair to death acceptance is not only practically important to support mission effectiveness, but also ethically important to fight justly in LSCO.

As I ponder on the current state of death despair in military medicine, I am also personally concerned with the hidden long-term costs of the COIN paradigm. In fact, I wonder if death despair is not a pathway for diseases of despair, a construct defined by pre-mature death due to suicide, substance abuse, or alcoholic liver damage. It is hard to ignore the fact that military care providers and catastrophically injured service members are at a high risk for all three.[140] This is made more poignant when reflecting the financial cost of continued care for catastrophic injuries placed on society. Often, the severely injured come home to die not directly at the hands of the enemy, but from drug overdose, alcoholism, or suicide.[141]

In contrast to literature that place the pathway at economic stagnation, I have mused on whether unsanctioned and unprocessed grief is not a more accurate pathway to diseases of despair in the military. When death despair dominates the military worldview, the on-going and never-ending losses that military care providers are exposed to are also hidden from view. Likewise, the losses

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136. *Id.*

137. *See* Jeff Greenberg et al., *Terror Management Theory of Self-Esteem and Cultural Worldviews: Empirical Assessments and Conceptual Refinements*, 29 ADVANCES EXPERIMENTAL SOC. PSYCHOL. 61, 65, 92 (1997).

138. *See* JESCHKE & HUFFMAN, *supra* note 28, at 72–74.

139. *See id.*

140. *See generally* OFFICE OF MENTAL HEALTH & SUICIDE PREVENTION, U.S. DEP'T OF VETERANS AFFAIRS, NATIONAL VETERAN SUICIDE PREVENTION ANNUAL REPORT 9 (2019) (discussing rates of suicide amongst veterans); Karen H. Seal et al., *Substance Use Disorders in Iraq and Afghanistan Veterans in VA Healthcare, 2001-2010: Implications for Screening, Diagnosis and Treatment*, 116 DRUG & ALCOHOL DEPENDENCE 93, 97 (2011) (discussing the prevalence of substance use disorders, including both alcohol and drugs).

141. Seal et al., *supra* note 140, at 97; OFFICE OF MENTAL HEALTH & SUICIDE PREVENTION, *supra* note 140, at 9.

experienced by catastrophically injured service members whose lives were saved are hidden from view. Grief becomes unsanctioned by the individual who sees it as failure, the organization who sees it as inefficient, and the society who sees it as pathology. As Emily Mayhew points out, most military care providers respond to the intensity of loss by saying: "I'll deal with all of this when I retire."[142] However, if not properly processed, the depth of loss that comes with armed conflict, creates a situation which Emmanuel Kantongole describes as "the living on top of [their] dead."[143] Kantongole's work focuses on the socio-political importance of communal healing after experiencing the violence and devastation of warfare.[144] He claims that the public dimension of mourning through a communal expression of grief is essential to healing the "cosmic bond[s] of human existence that are threatened by violence."[145] In other words, there can be no just and lasting peace erected from the human cost of war if the loss is not fully mourned by all as a social process of reconstruction. As a theological just war theorist who believes that the only proper reason for engaging in any armed conflict is the construction of a just and lasting peace, it is this concern that presses me most intellectually and personally.

Currently, grief is not communalized and accepted into the normative understanding about warfare in the military organization or civilian society and leaves individual care providers and injured service members on their own when attempting to navigate the emotionally chaotic experience of making meaning from their losses. The following narrative from a military care provider highlights this point:

> If you really believe that you were not affected … watching your patient die while you treated them in the mud and under fire—you are an idiot … I did not realise that the intimacy of just being present when a patient died would create an existential bond that would always be remembered … It was also likely that some decision made using an in-the-moment survival mentality would breach our own deeply held moral beliefs. And when we revisit them absent the drama and without the support of like-minded individuals, we know there can be no do-overs—only the do-laters that will become our challenges for the future.[146]

Whether or not the military ever engages in LSCO in the future, ritual mourning in support of nationalism is a reality with which I fundamentally believe we all need to address as an American society. While culturally, politically, medically, and militarily taboo, I believe it is essential to truly understand the ordinary—not the valorized—reality of what it means to prepare for, engage in, and come

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142.  MAYHEW, *supra* note 27, at 260.

143.  EMMANUEL KATONGOLE, BORN FROM LAMENT: THE THEOLOGY AND POLITICS OF HOPE IN AFRICA 72 (2017).

144.  *See id.* at 95.

145.  *Id.*

146.  Jeffrey L. Brown, *The Moral Matrix of Wartime Medicine*, INTIMA, Fall 2015, at 1, 5–6.

home from war. This includes the reality of death and dying for military care providers and the service members they support in deployment. Though mere speculation, it seems possible that death despair has also set up a set of conditions that make diseases of despair possible in the military. As such, treating death despair may be a pathway forward in reducing the number of preventable non-combat related deaths in the military.