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The Moral Matrix of Wartime Medicine

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My Arrival

A trim stewardess wearing a powder blue skirt and a pretty smile pushed her food cart down the center aisle. At first glance, this looked like a routine flight. It wasn't. The passengers were combat-ready troops who were mostly young, mostly somber, and mostly silent. Some chose sleep to escape from troubled thoughts; others anesthetized them with the droning white noise of powerful jet engines. One consequence of our rapid buildup in Vietnam was that soldiers were transported on commercial airlines. Another was that doctors like me had only six weeks of transition from civilian to military life before we shipped out with them. We wore summer weight khaki uniforms but felt like civilians right to the moment that overhead speakers crackled news of our arrival.

It was late August 1966 and monsoon rains would continue for another two months. The strong wind that delayed our landing had just blown by and we walked quickly through thick mist that smelled like wet wool. The sky was gray. Everything else was olive drab splattered with brown mud: boots, gear, vehicles—everything. Like the other military items that were stenciled with descriptors, I was labeled too. Captain's bars, a caduceus, and a plastic name tag announced what and who I was to anyone who was interested.

The Camp Alpha processing center for incoming troops was located near Saigon (now Ho Chi Minh City). It looked more like a tropical prison than a welcoming area. Heavily armed guards patrolled perimeter fences topped with coiled concertina wire. Screened and sandbagged barracks were separated by narrow rivers of muddy rainwater. Malaria-carrying mosquitoes fed on hot sweating skin. And, if not for a poorly tested vaccine, fleas from indigenous rats could infect us with the same bubonic plague that created medical mayhem during the Middle Ages. I was housed with other junior ranking officers. War noise and jet lag assured a miserable night's sleep.

At first light, a sergeant appeared. His ethnicity was nondescript, but his bearing was not. He was professional and unambiguously intimidating: straight back, athletic build, and piercing gaze. Somehow, his fatigues were pressed and his boots were shined despite the pouring rain and an absence of rain gear. This was quite remarkable. Either he was secreted away with us overnight or he possessed special powers that repelled mud and water.

"Attention to orders," he barked.

We paid attention.

"The following orders have been changed...."

I was assigned to the 2nd Battalion, 14th Infantry Regiment.

Other names and orders followed.

There were groans.

One came from me.

I stood tall, stepped forward, and did my impression of an Army officer.

"Sergeant," I said. "I am scheduled to join the 85th Evacuation Hospital in Qui Nohn. I am also classified 3-C because of a well-documented medical problem. This disallows an assignment to a combat unit and I want an explanation for this change of orders."

Without effort, he assumed the persona of a hotel manager denying a confirmed reservation.

"Sir," he said with a hint of condescension. "I am so sorry I can't help you. Your medical file seems to have disappeared in transit. I suggest you discuss these medical issues with the doctor when you get to the two-fourteen in Cu Chi."

"But you said that I am going to be the doctor at the two-fourteen."

"That's correct, Captain. Effective 0600 today, you are the battalion surgeon for the two-fourteen."

This man had not earned all those stripes for nothing. A few months later I would have responded to this ridiculous Catch 22 dialogue, but at the time, I was speechless. With luck, maybe a higher level of stress hormones would lessen my frequent bouts of asthma. That same afternoon, I was convoyed west to join elements of the "Tropic Lightening" 25th Infantry Division in central Vietnam. We drove on dirt roads through large areas of denuded landscape that had been sprayed with the herbicide Agent Orange. We were told it harmed only vegetation; human toxicity for those exposed is now measured in parts per billion. I felt like an imposter wearing a steel helmet, a bulky preKevlar flak jacket, and canvas jungle boots that were reinforced against hidden punji stakes. My accessorized vehicle foreshadowed what would come next: Sand bags to keep land mines from exploding through the floor, a slotted vertical bar to cut sharp wire strung neck-high across the road, and a locking cap to keep local kids from dropping hand grenades into the gas tank.

At Cu Chi, my 30 medics were armed and did not wear Red Cross insignia. Before being embedded with 900 infantry troops as their only doctor, I was issued an M-16 rifle and a .45 caliber pistol. Notwithstanding the Geneva Convention and my lack of weapons training, the Viet Cong were known to target medical personnel.

I was one year out of medical school and only a few weeks earlier worked as a medical intern in a respected teaching hospital. I had not decided on a career path and joined the military to avoid being drafted, but this assignment bore no resemblance to the psychiatric training program I had been promised. Clearly, the person who got me into this mess deserved more than just a simple reprimand. Unfortunately, the culprit was me.

The Mercy Killing

My first week in the field was uneventful; the few patients I saw had only minor complaints. On the morning of the eighth day, during my transition from mostly asleep to almost awake, I heard a shout, "Where's the doctor?" the voice said. I grabbed my gear and came running. Framed in the center of an empty dirt road, the backlit silhouette of a young soldier walked toward me; awkwardly, as though he was afraid of dropping something fragile. His deuce and a half (2½ ton truck) was parked to the side with its engine still running. Typical for soldiers at that time in Vietnam, he wore a helmet but no body armor, so I could see that his shirt was wet with dark red blood. An M-16 rifle was slung over his left shoulder because his arms were cradling a scraggly, malnourished, mixed-breed dog. Its brown fur was matted from the fine misty rain and it was whimpering in the most pitiful way.

The cause of the dog's pain was obvious. A two inch shard of whitish bone protruded through the torn flesh of its right hind leg. The soldier tried valiantly to protect the leg from moving but the dog's cries were evidence of his limited success. Despite holding the dog, he stood mostly at attention and addressed me in the staccato voice used for giving military report. "It was an accident, sir. I never saw him. It was dark, my headlights were dimmed, and there was a thud. I exited the vehicle and this is how I found him." The dog was not wearing tags or a collar. "Does he belong to anyone?" I asked. "I don't think so, sir. He just shows up. We play with him sometimes and feed him scraps but I've never seen anyone actually looking after him."

Involuntary tears left tracks on both cheeks. He studied the dog's pained face with the affection reserved for close friends and relatives. I am quite certain that today I would protect my dog's life with my own, but at the time I had little empathy for the depth of this man's emotion. His combat platoon received sniper fire a day before. Two members of his squad had been killed, others were seriously wounded, and these tears were shed for a stray dog. Successful treatment required the skill of a surgeon, a proper medical environment, and prolonged convalescence. These did not pertain to me, the situation, or the dog. Like all doctors assigned to military units, my title "surgeon" was vestigial from battlefields of much earlier wars and not based on meaningful surgical training. The equipment in my aid station was meager, and to make matters worse, we were packing up supplies before moving out the next day.

One of my medics approached from the rear. "I'm sorry," I said in a calm voice. "There isn't much we can do except relieve its pain." The dog was placed on a poncho at a spot that was shielded from the rain. I kneeled in the mud, repositioned the dog, and carefully propped the injured leg to what I thought was a more comfortable position. The dog yelped. I flinched. Without conversation, the medic handed me some ampoules of morphine. An average soldier weighs about six times more than this dog, so I reasoned that half an adult's lethal dose should end its life in a humane (sounds silly) way. Army medics love giving morphine, and for good reason. No matter how severe their patient's injury, it relieves pain and anxiety quickly. But on the dark side, a large dose can inhibit the brain center that controls breathing and cause death.

I located the vein that runs down the dog's foreleg, inserted the needle, and administered the first dose intravenously. Injecting it directly into the blood stream increases the drug's potency and protects against erratic absorption. Almost immediately, the dog closed its eyes and seemed at peace. I was relieved; sometimes pain causes more distress for the doctor than it does for the patient. Thankfully, I thought, this will be over soon. It wasn't. I injected a second larger dose, and then a third …. Nothing much happened. The dog's breathing slowed a bit, but it was not shallow. I doubled the next two doses ….The dog was still breathing normally and his pulse was strong as ever.

This was not going well. If death was the goal, it seemed nowhere in sight. And now I had wandered outside my comfort zone. I had never used medical knowledge to end a life and I didn't like the way it made me feel. I wondered if I had miscalculated the dose of morphine or whether my impulsive pragmatic morality was somehow being tested. In the very back of my mind, a third option was much scarier: Was it remotely possible that some spiritual force was telling me it was not time for this dog to die? I held my ground and injected more morphine …. The dog was still breathing …. more morphine …. still breathing …. And then, without warning, the dog was dead. I stopped breathing too and was devoid of thought and air

and sound. When I recovered, I refused to tell myself that I put the dog to sleep or out of his misery. It seemed necessary to acknowledge the gravity of what I had just done.

Once again, the soldier slung his rifle over a shoulder and then dropped to one knee. Taking great care to protect the dog's injured leg, his trembling hands hugged the still warm body to his chest. He paused and stared into my eyes. Plain words captured the complex amalgam of his sadness, betrayal, anger, and resignation. "I feel really miserable, sir," he said. I did not possess the medical magic that might have saved this dog's life nor the knowledge of how best to comfort this grieving man. I felt the pain that comes from admitting to one's own lack of competence. I surely hoped that one day I would acquire the requisite skills but at that place and time they were not mine.

I nodded, looked away, and said nothing.

The Mine Field

Most troops greeted me with "Doc, let me show you something." It is impossible to maintain decent hygiene living in the jungle or wading through rice paddy water, so the "something" was usually skin that was lacerated, abraded, ulcerated, blistered, weeping, or infected with bacteria and fungi. And since there are no private body parts in this setting, I did get to know these guys pretty well in relatively short order.

Our battalion was conducting search and destroy operations in Tay Ninh province near the Cambodian border. My new home was a small sandbagged tent that doubled as the forward medical aid station. It was located less than 100 yards from the perimeter machine guns, which meant we could be under fire while treating casualties. The triage and treatment area consisted of two canvas stretchers called litters that rested on metal racks. If necessary, we could expand its capacity by laying ponchos over the mud. There was no suction, no oxygen, no blood products—none of the medical stuff I had previously taken for granted. Changes in military tactics and helicopter evacuation of the wounded from point of injury had mostly relegated us to the role of highly-trained medics. So, over time, our job was phased out and most combat doctors were eventually transferred to better-equipped medical facilities. The higher command finally learned what we already knew—the added danger could not be justified.

Shortly after arriving, I embarrassed my novice-self by leading my medics on a frantic search for burn dressings. I heard there was a firefight and imagined that soldiers were using flame throwers. I didn't know that a "firefight" is an exchange of small arms fire. About five weeks later, that same inexperience compelled me to join two of my medics who were treating a critically wounded soldier. He had wandered into a well-marked minefield and they were having trouble keeping him alive. This area was adjacent to our operations center and had been seeded with "Bouncing Betty" landmines that contained a smaller first charge that lifted the second waist high before exploding. They inflicted terrible damage and an unfortunate misstep had mangled this man so badly that there were no obvious places to apply tourniquets. Not helping my medics did not seem like an option. And, like a mother running into traffic to save her child, I entered the minefield thinking of the danger as abstract, as though the mines did not pertain to me.

Our patient's bleeding had slowed because he was already in shock. I injected him with morphine, applied pressure dressings, managed to started IV fluids, and we placed him on a litter. Then, we exchanged glances, shrugged to acknowledge the frailty of our existence and without speaking – simply walked out. We were so close to each other that detonating a single

mine would injure all of us. This loss of control was a humbling experience. Our survival was solely dependent on a sequence of random near misses. If a boot struck the ground here, we were okay. If it struck there, we would most likely die.

We were covered with blood. The wounds were extensive and almost certainly lethal but the outcome was finalized while we waited for the Medevac team to arrive. He began copious vomiting, then gasped, and then breathed the vomit deep into his lungs. A well-intentioned soldier added to our frustration by pleading "Do something! Do something!" But with no suction available, we knew our attempts at resuscitation and clearing his airway were futile. The reality was, there wasn't much we could do except watch him struggle to breathe, suffocate, and die.

I don't know the name of the man who was injured, or the names of the brave medics who assisted me, or the name of the anxious soldier who had been annoying me. Unfortunately, it is his voice that I remember most. None of us spoke about this incident again; the next day would be just another day.

Epilogue

The sterile, almost clichéd term, "post-traumatic stress," belies the impact its symptoms have on those who are afflicted. Mild symptoms create bursts of emotional and physical complaints. But for some patients, they become so severe and pervasive that they disorder their lives. Anxiety, hyper-vigilance, self-doubt and depression are expected, but it is time disorientation that makes precipitant events seem contemporary and part of the present-day self. Older folks like me are always surprised when they become symptomatic long after the trauma has occurred: Aging veterans are more vulnerable physically, psychologically and financially, and they have more time for reflection. When I told a Veterans Affairs psychologist that I did not think my late-in-life symptoms were related to my Vietnam experience, he smiled. "If you really believe that you were not affected by running into a minefield, disarming a disturbed soldier while he was threatening to shoot you, and watching your patients die while you treated them in the mud and under fire – you are an idiot." I reluctantly admitted that maybe his diagnosis was correct. "Do you have a DSM code for this?" I asked.

Combat medical personnel who served years and sometimes decades earlier often describe their experiences as if they just happened. I believed that fear of personal injury would be the principal trigger for anxiety but their recollections were similar to mine: "Professional terror" was far worse than worry about physical harm. Given their less than optimal equipment and training, they rarely felt competent to fulfill professional responsibilities. Their psychological survival required a decision to make do with what they had – not what they wished they had, and having the ability to redefine what was an acceptable outcome and level of performance.

Doctors, nurses, medics and corpsmen also struggled with constant conflicts between the need to fulfill their unit's medical objectives and their obligations to individual patients. The military required us to keep troops healthy enough to fight, but we worried that treating patients to make them combat-ready might be writing them a prescription for death. These decisions made us weary because we viewed ourselves and the troops viewed us as their protectors – similar to the way that doctors interact their own families. The night before a dangerous mission, a soldier who complains of a severe headache relies on our intuition to determine whether to keep him safe on sick call. We both know there is no objective way to know how incapacitated he might become and whether his absence or a debilitated presence

would be more harmful to his squad. Then, the very next day, we might decide whether the correct triage decision was to risk a medevac crew's lives by insisting on a night-time landing or whether we should wait until morning and risk losing a critically ill patient. There were no "right" answers to these choices and the consequences would not always be easy to live with. I did not realize that the intimacy of just being present when a patient died would create an existential bond that would always be remembered. But I did naively believe that keeping patients alive at all costs was an uncomplicated goal until I was confronted with permanent brain injuries combined with the loss of multiple body parts. Is it "more" morally correct to preserve this life because we can or to not burden this man and his family for many years after his return? Even worse, we did not know what these soldiers would choose for themselves or what their families would decide if given the opportunity. Later, as a pediatrician searching for a way to accept the loss of so many young lives, I reasoned that those who died were not really cheated out of a longer life. By definition, a lifetime is the time from a person's birth to the time of his death. Its essence is not quantitative. Whether its existence is measured in minutes, days or years, it is always complete; it cannot be missing something that never was or would ever be.

Our matrix for morality was once painted in the clarity of primary colors. Now it was a kaleidoscopic jumble of moving parts. Medical personnel were issued weapons because they were targeted by the enemy. Women and children unexpectedly became dangerous assassins. Enemy soldiers placed innocent civilians at risk by not wearing uniforms and hiding in places of worship. Everything in our daily routine was potentially booby trapped and could literally explode at any time. The rules for war seemed to be wishful thinking and after our return, a hostile public betrayed and abandoned us by not distinguishing between an unpopular war and the warriors who were fighting it.

There is a great difference between being in a dangerous place where you might die and one where others actively try to kill you. The likelihood of making errors that would result in friendly casualties or harm innocent civilians was so great that it was accepted as inevitable. It was also likely that some decisions 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. If we allow ourselves to carefully examine the events and decisions that injured our moral-selves and ask, "What kind of person am I?", the answer will be very complicated.

Youth is not wasted on the young.
If we were wise during our youthful years,
We would not make the mistakes
And feel the pain that is
Required for learning life's lessons.
And if we could regain youth during our later years,
Its exuberance would overwhelm us
So we could no longer see the world
Through wise eyes. *– JLB*

Jeffrey Brown teaches as a Clinical Professor at New York Medical College and at Weill Cornell. He has written three published book titles and many papers, articles, and book chapters. Before residency training, he served in Vietnam as a combat Army doctor where he was awarded a Bronze Star for Valor. Caring for sick and injured children in local villages resulted in his eventual career choice to become a pediatrician. Brown recently retired after forty years of full-time practice in Westchester County NY and has been active in improving the healthcare that veterans receive from community physicians. He also lectures on how moral injuries from wartime experiences affect soldiers following their return to civilian life.