Medics and Mortality: Discussing Death in Modern Military Medical Training

by Ann Jeschke, Ph.D.

On September 20, 2017, Secretary of Defense James Mattis articulated three lines of effort for the Department of Defense; the first being to construct a more lethal and ready military force. When thinking about this first line of effort, more powerful equipment and combat training for warfighters might seem like a straightforward path to achieving this goal. Upon closer scrutiny, a great deal more than training and equipping warfighters is involved when discussing a lethal and ready force. Often unmentioned, the military medical corps plays a significant role in ensuring a ready force. This is especially true considering that Mattis is "committed to improving the combat preparedness, lethality, survivability, and resiliency of our nation's ground close combat formations."[1] The military medical corps not only provides force health protection in terms of preventative medical treatment that keeps warfighters combat ready, but it also increases survivability by providing the world's best trauma care both on and off the battlefield. Additionally, operational psychologists work to ensure the mental stamina of those who will engage in fighting on the ground. As such, the goal of achieving a more lethal and ready ground force places a heavy burden on the military medical corps as they will be tasked with ensuring the survivability and resilience of warfighters.

While there is a great deal of military medical research related to how the military medical corps can promote both survivability and resilience in operational ground units, there is little discussion on how an increased training tempo and lethality would affect the needs of the military medical corps. Moreover, emerging conflicts present an added challenge; namely, anti-access and area denial that will impede immediate long-distance medical evacuation of injured warfighters. The practical implication of a protracted time before medical evacuation is that combat medics[2] will be required to take on a broader scope of practice. Medics will not only provide immediate life-saving interventions at the point of injury on the battlefield, but they will also be asked to provide extended critical care management as well as palliation for those warfighters who are in active death. Mattis' goals and the nature of future conflict leads to questions about how to best ensure medical readiness and resilience in military clinicians. Since medics will take on a lion's share of the medical burden, I wish to broadly consider what training is necessary to properly prepare medics to provide combat casualty care within these new conditions.

My goal in this paper is not to provide a strong normative argument. Instead, I want to reflect on an interesting absence I noted when studying tactical combat casualty care (TCCC) and prolonged field care (PFC) training manuals.[3] Specifically, I saw that training focuses solely on life-saving procedures and any mention of death is strikingly absent. As a civilian, one of the first things I think about when reflecting on combat is death. To me it seemed obvious that a medic would need to prepare for the possibility of death. Looking at triage categories it might appear that death is addressed through the category of expectant, which is a combat casualty that overwhelms the available medical resources and is at the end of life. While the concept of possible death is implicit in the expectant triage category, the word death is never present, nor the fact that a warfighter might die in the care of a medic. In fact, combat casualty care training manuals suggest that expectant comrades be placed to the side while focus shifts to other comrades with "salvageable" injuries.[4] There is no training or insight provided on how to deal with an expectant casualty.

I am starting from the assumption that addressing death in the combat casualty care training would be a good change in doctrine. I have come to realize that many individuals object to my basic starting point. However, if it is reasonable to train the warfighter like she fights, then engaging the reality of death as a strong possibility would be important an aspect of combat casualty care training; especially, considering the shift to PFC with increased lethality on the battlefield. Before addressing specifics about how to properly train medics for future armed conflict, I will perform a more conceptual reflection that can be used as background to more detailed future research. In this paper, I speculate on why death is not part of the standard curriculum. Thereafter, I suggest that overlooking death might have negative consequences for the medic in terms of both casualty care as well as the medic's mental stamina. Finally, I offer initial insights for bringing death into combat casualty care training. This exploratory paper will provide the groundwork for better understanding what competencies a medic might need to succeed at her role within the constraints of the future battlefield as well as when and how such competencies could be integrated into combat casualty care training courses.

Realizing that combat casualty care training manuals did not affirm my assumption that death is a likely reality for which the medic should be prepared, I became curious about what might be causing the reticence to directly address death and speak in a language that is not shrouded in euphemism. Turning now to that topic, I will explore several factors that might be influencing combat casualty care doctrine.

Why is Death Missing

When I started to research on why death is absent from combat casualty care doctrine, what I found was that military medicine is situated in a unique modern scientific worldview. Acknowledging death within modern medicine or modernity in general is more complicated than it seemed at first blush, even when discussing the reality of combat. My first insight came from Atul Gawande's book *Being Mortal*. In this book, Gawande walks through his own experience of confronting death as a physician practicing modern medicine. He explains that his training did not prepare him for the reality of human mortality. "Our textbooks had almost nothing on aging or frailty or dying … The way we saw it, and the way our professors saw it, the purpose of medical schooling was to teach how to save lives, not how to tend to their demise."[5] Gawande's personal memoir helped me understand that the avoidance of death was not simply due to something implicit in combat casualty care training. Instead, it pointed me to larger assumptions embedded in the training, practice, and purpose of modern medicine. Mostly, a hidden assumption that death can be overcome through modern medical science and technology.

Robert Kavanaugh, a thanatologist writing in the 1970's confirmed Gawande's personal experience. Discussing his own reflections on the revolution of scientific medicine Kavanaugh said, "I heard a famous scientist boast that modern medicine has added more reality to the age-old concept of immortality than all the theologians and churchmen in history combine."[6] I was personally intrigued by this admission because it was disclosed at the advent of modern medical technology. Technological medicine now has the capacity to keep individuals alive under the most extraordinary circumstances. George N. Marshall suggests that the hope of immortality can be seen in scientific excitement about technologies such as "deep-freeze preservation of bodies for future restoration."[7] It is as if technology has hidden the reality of death behind the possibility of survival through advanced medical technologies. Thus, medicine no longer needs to grapple with the fact that all human beings will die because medicine is questioning that primordial assumption. However, Marshall suggests that the more "we advance science, technology, and institutional solutions" to prolonging death, "the more we fear death" and anxiously attempt to control it.[8]

Perhaps the need to control and overcome death is because it is no longer a workaday aspect of human existence. In contrast, it is something to be defended against as the typical modern medical language suggests. A quote from Stephen J. Gould after being diagnosed with terminal cancer epitomizes the general orientation of modern scientific medicine toward death. He says:

> "It has become, in my view, a bit too trendy to regard the acceptance of death as something tantamount to intrinsic dignity. Of course, I agree with the preacher of Ecclesiastes that there is a time to love and a time to die—and when my skein runs out I hope to face the end calmly and in my own way. For most situations, however, I prefer the more martial view that death is the ultimate enemy—and I find nothing reproachable in those who rage mightily against the dying of the light."[9]

Gould made this comment in an article suggesting that hope can be found in the long tail of statistics. Being a famous evolutionary biologist who had a rich understanding of statistics, he literately took odds with the idea that the literature on mesothelioma presented; namely that the "median mortality of eight months" meant that he would likely be "dead in eight months."[10] Instead he chose to re-interpret the studies with a great deal of nuance to steel himself against mortality as the most likely outcome.

Advances in biology have also kept the focus on life-saving advancements and ignored the physiological processes related to wear and tear on the body leading to eventual death. As Robert Pollack suggests: "both biology and medicine have become stuck in a long series of persistent, clever but useless attempts to ignore [death]: medicine by insisting that death is a failure, and biology by insisting that death is not interesting."[11] In other words, biological research sees the process of dying as not worthy of scientific reflection and medicine sees death as a denial of its own mission and purpose.

Lest I paint a picture that modern medical research is single-mindedly perpetrating a conspiracy against discussions on death, I want to illustrate that there are broader social realities beyond modern medicine that influence how combat casualty care training manuals are constructed. In performing his research on how to create options for a dignified death, Marshall encountered resistance to speaking of death in the young men. Marshall was confronted with a stinging question: "How can any red-blooded, active person be concerned with death?"[12] A similar scornful comment was shot at me when I began this research. I was asked, "Why should military medical research waste its time on death when those in combat arms are typically young healthy men?" My simple retort at the time was, "They are going into combat." To me it was obvious. Yet, it was as if this military medical researcher could not conceive that death was an option in combat; especially not one that medical research could not overcome given enough resources. This led me to realize that there is an even greater social force at play when talking about death. To me combat did not simply equate healthy young men in the prime of their life, as the reader likely recognizes by now, it also equated the possibility of death. However, such attitudes are deeply embedded in what Christina Staudt calls a "Death System." Staudt's definition of a death system is "everything related to death in a society,"[13] which she simplifies from John Morgan's more complex and comprehensive definition.

Staudt's brilliant historiography of the current American Death system, helped me realize that avoidance of death is grounded in our broader death-denying Western culture. With the onset of the modern industrial revolution, death denial became the paradigmatic attitude toward death which persisted through the entire 20th century. In fact, Staudt suggests that death became so taboo in the 20th century that it was equivalent to pornography in the Victorian era. Death denial was the primary mechanism for individuals dealing with the reality of death. Relying on Elizabeth Kübler-Ross's research, Staudt says that the practical result of a death-denying society is that it isolates and ignores anything that is a reminder of death because such action serves to avoid direct confrontation with human mortality.[14] Such an isolation can be seen in the way expectant injuries are to be set to the side in combat casualty care doctrine. While the goal is likely to avoid emotional distress for the other injured warfighters as well as clinicians, it also ends up ignoring the reality of death.

With the introduction of medical technology in the last quarter of the 20th century, Staudt suggests that death denial morphed into a form of death control through the "unrestricted use of all-out technologies to keep a person alive."[15] As such, death's current cultural cloaking devise creates an expectation that medical clinician's and researchers will do everything to keep individuals alive against all odds or figure out how to

do so. It is within this latest shift in the American death-system that current combat casualty care training and research has been developed.

Modern medical technology and scientific research, while amazing in their discoveries and capabilities, are situated in a broader worldview that influences the social appreciation of death. Taken together combat casualty care training doctrine is influenced by a modern society and medical landscape that focuses on survivability and life-saving measures while wanting to overcome death as the enemy of human nature. As Gawande explains, "medicine exists to fight death and disease, and that is of course, its most basic task."[16] While the modern worldview and practice of medicine may have established death as the enemy, Gawande submits that "the enemy has superior forces. Eventually, [death] wins."[17] Considering the cultural terrain within which modern medicine operates, Elizabeth Kübler-Ross says that scientifically trained medical clinicians "cannot deal with death or are uncomfortable facing it."[18] Military medicine is not immune to these death-defying trends when considering the advancements in combat casualty care over the last 20 years. However, no amount of medical, scientific, or technological advancement can eradicate death from the battlefield or even life itself. To ignore death is to leave the medic unprepared to face the reality of combat.

In assuming that death should be part of the combat casualty care training doctrine, I have shown that there are far greater medical, social, and historical forces at play than simple ignorance or avoidance on the part of the military medical corps. In contrast, the idea of speaking about death in combat casualty care training is quite counter cultural. For these reasons, I want to turn next to explore what might be the potential consequences of not talking about death in the combat casualty care training.

Consequences of Not Talking about Death

As I begin this section, I also am working on the assumption that anxiety and distress are made more poignant when there is a lack of understanding or familiarity with a phenomenon. To avoid the topic of death in combat casualty care training would be to set up potentially challenging consequences for both the dying warfighter and the medic. As I pondered my own relationship to death, I could not deny that I have been swept up into a death avoidant attitude. Death is not something that I have often encountered other than in abstract thinking. It is not that people I know have not died. Yet, I have a limited vocabulary with which to talk about my own experiences of death. Therefore, to better understand the consequences of death avoidance for the medic, I not only read books on the topic of death and dying, but I also spoke with military clinicians who worked in combat casualty care and operational psychology.

One of the most profound stories came from a clinician who training medical students to triage wounded in a mock combat scenario. This clinician watched as medical students moved emergent casualties behind doors where they could not be seen. It was not due to malicious intent nor to having been overly influenced by a deep understanding of combat casualty care procedures as these were untrained students. It simply appeared to be the most expedient and unemotional way to deal with the reality that some casualties were dying, and resources were limited. My colleague was mortified and tried to impart to these students that a warfighter deserved more for her service than to be left alone to die in a back corner. From an outside perspective, it was easy to cringe at this disregard for someone in the last stages of life. However, I could not be sure I would have done any different if given the opportunity. Like these students, I have had no direct confrontation with someone who is actively dying and possess no language or skills to directly face death in another person and appropriately engage.

Although not triaged as emergent combat casualties, Kavanaugh's interviews with dying individuals shed light on how those who are dying feel when their immanent death is ignored. One woman describes her experience of dying as an artificial attitude of perfect, yet distant, care:

> The whole rigmarole of dying has become an irking bore. Two doctors stop by irregularly to check my comfort level and push their pills. My minister came almost every day until I foolishly told him I thought I was falling in love with him. Now he comes about twice a week when Arnold is here and reads or prays for me. I suppose he is too uncomfortable to deal personally with me, probably afraid I will cause a scene. The nurses are super to me, almost too perfect in answering every need. I'd feel better if somebody around here would goof so I could crab and complain. It certainly would be more like the real me … Never in my life have I felt more alone.[19]

As I read this story, I envisioned a group of automatons that interacted in a pleasant yet uninvolved manner. Such a flat, innocuous experience was not perceived by the dying woman as meaningful or helpful. There was no human complexity or richness in her interactions. In fact, it all seemed a bit like a ruse.

One of the classical literary texts on dying is Tolstoy's *The Death of Ivan Ilyich*. This text is often read in medical humanities curriculum when discussing end of life issues because it poignantly portrays the depth of anguish experienced by Ilyich:

> What tormented Ivan Ilych most was the deception, the lie, which for some reason they all accepted, that he was not dying but was simply ill, and he only need keep quiet and undergo a treatment and then something very good would result … This deception tortured him—their not wishing to admit what they all knew and what he knew, but wanting to lie to him concerning his terrible condition, and wishing and forcing him to participate in that lie. Those lies—lies enacted over him on the eve of his death and destined to degrade this awful, solemn act to the level of their visitings, their curtains, their sturgeon for dinner—were a terrible agony for Ivan Ilych. And strangely enough, many times when they were going through their antics over him he had been within a hairbreadth of calling out to them: "Stop lying! You know and I know that I am dying. Then at least stop lying about it!" But he had never had the spirit to do it … Apart from this lying, or because of it, what most tormented Ivan Ilych was that no one pitied him as he wished to be pitied. At certain moments after prolonged suffering he wished most of all (though he would have been ashamed to confess it) for someone to pity him as a sick child is pitied. He longed to be petted and comforted.[20]

Not only does this literary masterpiece affirm the pain felt by the woman above, but it also points out what was lacking from Ilyich's final days of life; namely, the need for human closeness and compassion. Ilyich longed to be comforted through human touch and caressing, which even to him seemed a bit infantile.

Reflecting on these stories as well as the goal of isolating emergent casualties from view of others, it seems likely that a potential consequence of denying death in combat casualty care doctrine is that it will lead medics to either completely ignore the warfighter or simply disengage from connecting to the dying warfighter's emotions, needs, and final wishes. I recognize that combat casualty care is performed under the most austere and extreme circumstances. Some might argue that the medic simply does not have the spare resources to attend to the dying in a meaningful way. Such attention to someone who cannot re-engage the fight might diminish not conserve the fighting force. I concede that resources are limited and that such attention to the needs of the dying will further tax the medic. However, to ignore this reality also places emotional burdens on the medic that could reduce her medical readiness and resilience.

Returning to the conversation I had with my colleague, we pondered if ignoring death was good for clinicians. I was surprised because my colleague was sure that ignoring death in the military was a good thing because it kept morale high and helped people seem invincible. To engage the idea of death might decrease combat readiness in the modern warfighter. An invincible attitude was, in theory, good for modern warfare because it inoculated the warfighter against the mental and emotional distress that thinking of

death might cause. In other words, avoiding death should promote resilience. Again, I was somewhat taken aback by this insight because I was aware of other ancient and classical notions of warriorhood that viewed death in combat as an honorable outcome for the warfighter. Knowing my colleague had worked with many medics, I asked what the long-term consequences of not confronting death might be for a medic once she returned home. After pausing, my colleague suggested that the consequences were psychologically profound as medics construct an identity that is concerned solely with saving life.

The following narrative affirms the damage that can be done to a clinician's sense of self-worth and emotional health when not prepared to confront the reality of death. Gawande describes his initial reaction when he first faced death and realized that medicine was not capable of saving everyone:

> "When I became a doctor, I crossed over to the other side of the hospital doors, and although I had grown up with two doctors for parents, everything I saw was new to me. I had certainly never seen anyone die before and when I did it came as a shock … Somehow the concept [of death] didn't occur to me, even when I saw people my own age die. I had a white coat on; they had a hospital gown. I couldn't quite picture it the other way around … The shock to me therefore was seeing medicine not pull people through. I knew theoretically that my patients could die, of course, but every actual instance seemed like a violation, as if the rules I thought we were playing by were broken … When I saw my first deaths, I was too guarded to cry. But I dreamt about them. I had recurring nightmares in which I'd find my patients' corpses in my house—in my own bed … I felt that I'd killed these people. I'd failed."[21]

Gawande's shock was twofold. The initial hit he took was that modern medicine was not able to fix all things. The rational response was that Gawande perceived himself as a failure. Grappling with the unaddressed reality of death weighed heavily on his conscience as he struggled to psychologically integrate what he was experiencing.

Jon Kerstetter, a military physician with extensive training in combat casualty care describes a deeper existential change that occurred when he first encountered the reality of combat. He says:

> "You trained well, but now you think all those war games and evac scenarios didn't prepare you. You're right. How could they? This is real. The fear and the blood and the shit are real. Death is real. War is real … Despite what you feel, you move out anyway. As you do, you sense that the mysterious alchemy of war has transformed your nature."[22]

Kerstetter does not describe what this transformation does to him, but he does say that when he failed to save lives he, like Gawande, felt personally responsible for the outcome. Kerstetter agonized over not having done enough to prevent untoward complications. He even stated that being a good military clinician meant carrying the emotional burden of this interior conflict.[23]

Though these narratives are not from the voices of medics, they serve to highlight a reality that weighs on the consciences of clinicians; namely, that their professional identity is rocked to the core when they confront the reality of death. Such a challenge is likely exacerbated for the medic because she cares for her comrades with whom she has become intensely bonded. The death of a comrade likely courses deeper than a patient with whom a civilian clinician maintains a certain clinical distance. Ignoring the reality of death might also cause the emotional needs of the medic to be overlooked. In specific, her need for appropriate time and resources with which to engage in grief processing.

When someone dies there is a normal grieving process. However, when grief processing is not attended too it leads to many psycho-social sequelae. The process of grieving is often stopped short for many because in a death denying society this process is seen as weak. Seeming or feeling weak is a foreign concept to

most individuals in the military; including the medic. The need to remain in control and effective might exacerbate the challenge of engaging in healthy grief processing.

In exploring healthy grief processing, Marshall compares a grief repressed individual and one that is properly working through her emotions. This example provides a cautionary tale to a modern culture that loves to see people mettle through death without blinking an eye. In an envious letter Marshall received from a mourning widow, he shows that grieving is not a neatly packaged emotional process. In contrast, it runs contrary to the Western emotionally stoic approach to death:

> "[A] woman wrote that she and her friend were both in the same congregation when their husbands died at approximately the same time. Her friend continued right along in her community, church, and club activities, even taking on new duties. Everyone seemed to admire her courage, spirit, and sense of strength. On the other hand, my correspondent could do very little. She was lethargic by comparison, not able to carry on, but was haunted by the comparisons she felt others must make between the two of them. She wondered why she was so weak. Today, over seven months later, her friend has had a complete mental collapse and is in a mental hospital; my correspondent has gradually found new strength and purpose, has overcome … her grief, and is now living, she believes, a normal life, adjusted to her new circumstances. She was apparently able to make the transition accepting in time the reality of the death of her husband, extracting some of the investment in the past, and reinvesting in the present and future."[24]

The comparison between these two widows illustrates how side-stepping the grieving process can be damaging to a human being's long term psychological health. To turn back to my intro, the reader will recall that the military medical corps is tasked with forwarding psychological resilience for the warfighter. One of the consequences of not addressing death might be a decline in psychological resilience as medic's will not understand what is happening to them if they are not familiarized with the chaotic emotions that grief processing entails. As such, they may stop the process short to remain in control.

Clearly, I am concerned with the consequences of modern scientific medicine in relationship to mortality. My goal is not to paint a cynical picture nor to find fault with any thread of this complex reality, to do so would be to also strip the world of the positive benefits that have been gained through modern scientific medicine. However, it is important to highlight that the avoidance of death has profound consequences for the dying warfighter as well as the medic. Finding inroads to changing the current path is not without serious challenges considering that death has become such an invisible force in modern medicine. The difficulty of addressing death is again illustrated by Gawande, who says that when he was first asked if a patient was dying he had no answer because after his medical training he longer understood what dying meant, how to diagnose it, or what it looked like. He says that the current focus on life-saving procedures "has rendered obsolete centuries of experience, tradition, and language about our mortality."[25] Although bringing death back into the conversation is a large challenge, I do not believe it is impossible. It is to this task that I turn in the next section.

Implications: Possibilities for Bringing Death into the Discussion

Having undertaken an intellectual journey to explore death, I wanted to try and practice what I might end up preaching. In putting myself to this task, I have not come any closer to directly engaging death. Unfortunately, I was left a bit empty-handed as my own adventure with death remains abstract. Marshall, referencing advice from Dr. Johan Branter, suggested that one way to bring death into the daily life is to attend more funerals at which one is not the central mourner.[26] I was only able to attend one funeral in the last year and I played the dutiful death denying role of observant researcher who approached the entire experience from a rather anti-septic and clinical perspective. A detached mechanical encounter with death

is the very thing I worry about in modern medicine; yet, I was unable to overcome that same style of facing death. I felt at loggerheads because I could not get beyond the interpersonal habits that afforded comfort when operating within a death-denying culture. Edgar N. Jackson's commentary was accurate when he suggested that the power of cultural norms quickly pervert the researcher when attempting to make general considerations about how best to engage death.[27]

I share this as a personal journey to be clear that I am by no means an expert. In fact, I am a neophyte researcher when it comes to end of life on the battlefield. My goal in this section is not to provide solutions to the challenges discussed in the first two sections. However, I wish to reflect on a few changes that might build a foundation upon which sustainable change for combat casualty care training could occur. Bringing death back into the foreground will not happen overnight, and the first step may not include a direct confrontation with death. As I have illustrated throughout this paper, directly facing death has come as an emotional shock for most clinicians.

My main suggestion is to have a method for addressing the emotional reality of confronting death that is embedded in training. In didactic training, books or personal memoirs of clinicians could be used as a discussion guide for entering a general conversation about death. Such training would be best developed in conjunction with senior ranking medics who have been deployed to accurately appropriate the military language, culture, and ethos. Other subject matter experts on end of life ethics could advice and lead discussion. Starting from a theoretical perspective it could be helpful to ask general broad questions such as: why is death absent from much of medical discourse? Simply realizing death is absent and questioning why death has taken a holiday would allow medics in training to develop their own insights in a safe environment at an emotional distance. Such a conversation will also allow for the unfolding of awareness in the medic's mind and start to shift her imagination.

Thereafter, these same stories can serve as a springboard for voicing more personal concerns or questions about what it is like to confront death. Such a discussion would allow the seasoned medical trainers who have been deployed to frankly engage their experiences with death in combat casualty care. Discussions could take many forms and would allow medics in training to reflect on what emotions they might experience when encountering death. Kavanaugh says that one of the most important aspects of attending the dying process is that the living participant "get in touch with [her] visceral feelings."[28] Some natural emotions related to confronting death are: embarrassment, fear, avoidance, anger, uneasiness, clamminess, distress, apathy, and disdain for the dying person. Visceral feelings emerge quickly in the face of death and take many by surprise because they are powerful and uncomfortable emotions that tend to distract.[29] Setting up a discussion context where medics in training hear about the visceral feelings others have experienced establishes a cognitive context for what they will encounter when performing combat casualty care.

Another avenue would be to create mock death scenarios built into medical skills training. When a medic is asked to triage injured warfighters in a simulated environment, trainers could require the medic to communicate to the warfighter that she is dying. This would allow for visceral emotions to emerge and allow the medic to wrestle with how to communicate difficult truths while also being attentive to the dying warfighter. Simulated scenarios where medics must interface with dying warfighters will allow medics in training to fumble in a non-life-threatening environment. Such simulations also allow the medic to become familiarized with her own tendencies and receive feedback from peers about what worked well and what did not in terms of caring for the dying warfighter. Even if medics show resistance to "play acting death" in training, simulations could be a potent learning tool because they would familiarize medics in training with their own avoidance of death. All of this would create a context that could start to move the medic away from identifying solely with providing life-saving procedures. Simulations also allow more seasoned trainers to impart wisdom concerning how they handled death and dying in combat casualty care.

Finally, it is important to have debriefing scenarios both in training. Likely, this would lead to conversations of embarrassment, awkwardness, and even concerns about futility of care. Such debriefing scenarios will also highlight how providing combat casualty care is physically and psychologically taxing on the medic. Providing solidarity and understanding in a group de-briefing can help to buffer some of resentment by allowing the healthy process of venting and reflecting on frustrations as well as growth opportunities. Allowing medics an environment in which they can reflect on the personal and interpersonal reactions they have in relationship to death will help them process their experiences before being deployed. This sort of emotional and cognitive processing is important in becoming more attuned to the intricate rhythms of combat casualty care and will help more realistically prepare a medic for her future work.

Taking up death in the theoretical, medical, and personal contexts within training will help provide a foundation upon which the medic can process future encounters and emotions. If there is no context against which to compare her experience, emotions may come upon a medic and catch her unaware. As such, familiarizing medics with death and offering a way to begin developing death-consciousness in combat casualty care will hopefully lead to better care for the dying warfighter as well as a certain amount of emotional processing before the medic must face death in real-time. All of this leads to broader concerns about how to avoid stretching the already over-extended military medical corps to a breaking point. The goal should be to integrate these concepts into what is already in place in a meaningful way.

Conclusion

In this paper, I have attempted to engage the behemoth task of addressing death in combat casualty care training. First, I explored some of the factors that might be influencing the absence of death training doctrine. Thereafter, I articulated some of the possible negative consequences of failing to address death. Finally, I provided a brief set of insights that could be used as a starting point from which to move forward in researching ways to best prepare a medic to care for dying warfighters on the battlefield. Since this is a new area of research, it will be important to begin with qualitative studies because they allow for the development of innovative constructs that are culturally sensitive. Querying experienced medics who are the subject matter experts of combat casualty care will enable researchers to develop a deeper knowledge of what is already operant, what is needed, and how to structure such training. Finally, this paper also has implications for research on medic self-care and grief processing upon returning home from deployment. The latter is a topic I hope to take up in future research.

End Notes

1 Matthew Cox, "Mattis Wants Ground Combat Units to Be More Lethal in the Close Fight," Military.com, February 23, 2018, 1, https://www.military.com/daily-news/2018/02/23/mattis-wants-ground-combat-units-be-more-lethal-close-fight.html.

2 I will refer to combat medics from this point forward simply as medics. I realize that there are many varieties of medic and corpsmen across the military. This paper is speaking to those military medics who participate in operational medicine and provide combat casualty care.

3 I will simply refer to the work and training performed by combat medics as "combat casualty care" in general. I recognize that there are specific differences between TCCC and PFC as well as other modes of care performed by clinicians who are not medics. This will help to simplify my language as the objective is to provide health care to combat casualties. Also the overarching set of doctrine on combat casualty care writ large all focuses singularly on life-saving procedures.

4 Miguel A. Cubano and Martha K. Lenhart, *Emergency War Surgery* (Government Printing Office, 2014), 30–31.

5 Atul Gawande, *Being Mortal: Medicine and What Matters in the End*, First edition (New York, New York: Metropolitan Books, Henry Holt and Company, 2014), 1.

6 Robert Kavanaugh, *Facing Death* (Los Angeles: Nash Pub, 1973), 6.

7 George N. Marshall, *Facing Death and Grief: A Sensible Perspective for the Modern Person* (Buffalo, N.Y: Prometheus Books, 1981), 4.

8 Ibid., 28.

9 Stephen Jay Gould, "The Median Isn't the Message," *Virtual Mentor* 15, no. 1 (January 1, 2013): 77, https://doi.org/10.1001/virtualmentor.2013.15.1.mnar1-1301.

10 Ibid.

11 Robert Pollack, "Forward," in *Our Changing Journey to the End: Reshaping Death, Dying,and Grief in America*, ed. Christina Staudt and J. Harold Ellens (Santa Barbara, California: Praeger, 2014), vii.

12 Marshall, 5.

13 Christina Staudt, "Introduction: A Bird's Eye View of the Territory," in *Our Changing Journey to the End: Reshaping Death, Dying,and Grief in America*, ed. Christina Staudt and J. Harold Ellens (Santa Barbara, California: Praeger, 2014), 4.

14 Ibid., 5–7.

15 Ibid., 8–9.

16 Gawande, 187.

17 Ibid., 187.

18 Elizabeth Kübler-Ross, *On Death and Dying* (New York: Scribner, 1969), 246.

19 Kavanaugh, 42–43.

20 Leo Tolstoy, *The Death of Iván Ilỳch: And Other Stories*, trans. JD Duff and Aylmer Maude, vol. 654, Signet Classic (New York, N.Y.: New American Publisher, Inc, 1960), 137.

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