

Reimagining “Honorable Death” in Future Large Scale Combat Operations

E. Ann Jeschke, Ph.D. and Sarah L. Huffman, Ph.D.

Advances in military and medical capabilities experienced in Iraq and Afghanistan codified the aspirational ideal of “leave no man behind” into an expectation to save the lives of all injured warfighters under all circumstances. Over the past two decades, the ability to deliver advanced medical care on and off the battlefield has allowed for an unprecedented overall survival rate exceeding 90%. Confronting near-peer adversaries in large scale combat operations (LSCO) on a multi-domain battlefield poses new challenges to combat casualty care making it frighteningly more complex. LSCO distributed across vast geographic space, combined with anti-access and area denial, means longer evacuation times and greater distances between care facilities as compared to those encountered in the counter insurgency and stability operations of recent decades. Some experts project that fighting a near-peer enemy in LSCO will result in thousands of casualties at one time. Military necessity will restrict medical access, govern distribution of scarce medical resources, and compel triage management. Specifically, LSCO could dictate triage based on return to duty versus saving all lives and retrieving the dead from the battlefield.

The anticipated reality of LSCO challenges the current expectation that combat casualty care providers should save the lives of all injured warfighters. Having forged an expectation that life-saving medical care will be provided to all warfighters, failure to provide medical care is likely to provoke fear in warfighters, health care providers, the military organization, and society alike even if it is militarily necessary. As such, LSCO gives rise to the ethical question of how to reframe what it means to support a “good death” on and off the battlefield. Implicit in this ethical challenge is the need to embrace battlefield mortality in a way that maintains human dignity during the dying process.

Considering combat casualty care in the context LSCO, we reflect on the broad question of how to honor injured warfighters within the limitations of a mass casualty scenario. To narrow our scope, we focus on expectant casualties. By analyzing a medical case, we suggest that one potential way to honor the human dignity of an expectant warfighter is to bear witness to his/her death narrative in such a way that the warfighter is provided an opportunity to participate in meaning-making relative to his/her life-story. Our goal is not to provide a strong normative argument against what has been done in counterinsurgency operations or for our view point. In comparing how honor is currently being given in combat casualty care to a possible way of honoring the expectant casualty in LSCO, we in no way seek to imply that our insights for the future are better than what is currently operant. Furthermore, we are not suggesting that providing life-saving medical care has been a waste of resources or is unethical. Instead, we want to initiate reflection and discussion on ways to support a good death within LSCO without deflecting necessary medical resources away from the tactical reality of the battlefield.

Outline of Paper

Our paper is composed of four main sections. We begin by giving background on who we are as authors as well as the key terms we are using as part of our analysis. Next, we present a medical case that serves as an exemplar of how combat casualty care manages catastrophic injuries in the counterinsurgency environment. In the subsequent two sections, we compare how combat casualty care providers honor human dignity

during the dying process in counterinsurgency operations to how it might be expressed in LSCO. To do this we analyze resource allocation, the relationship of the care provider to the dying warfighter, and how death functions in the warfighter's life-story.

Section One: Authors' Backgrounds and Key Terms

Realizing that we, as authors, are relying on the interpretive analysis of a medical case, which is a specific form of narrative, it is important to begin by presenting a brief explanation of our respective formation and disciplinary understanding of death in warfare. We assume that each of our respective personal histories will bring different interpretive insights and assumptions to the analytic process. Our goal is to bring our worldviews to this process and allow them to be challenged, thus, creating deeper understanding on a heretofore unaddressed topic in contemporary military medical ethics. In this paper, unless otherwise noted, the term "we" solely refers to the mutual analysis provided by E. Ann Jeschke and Sarah L. Huffman as authors. "I" will be used when either author is singularly speaking to her own unique experience.

E. Ann Jeschke

My, E. Ann Jeschke, doctoral training is in health care ethics with a focus on combat casualty care. My unique research interests began by looking at the embodied experience of providing health care on the battlefield. I came to realize that my innate academic curiosity is driven by exploring obvious realities that are often concealed or taken-for-granted in everyday life. For instance, my dissertation research was concerned with the lack of discussion of the body in relationship to the felt-sense reality of going to and coming home from war. Two years ago, I attended the Military Health System Research Symposium and an Army physician asked me how physicians should ethically train medics to attend death in combat. After spending a year reading various books, articles, and personal memoirs, I realized that death, like the embodied warrior, was a concealed reality in modern military medicine and in my own life. Academically, I also began exploring how death was implicitly operating in modern medicine and, in turn, military medicine. Personally, I became interested in understanding my own relationship to death.

In terms of ethical inquiry, I am invested in understanding and articulating best practices for providing care in crisis from the lived experience of those men and women who serve in the military. I rely on a broad definition of "care" that goes beyond medical intervention. I have addressed both how military health care providers "should" render care as well as what type of care should be given to the military health care provider. The common thread that has knit together all my projects is an ethical concern for how I, as a civilian, respect the individual warrior identity as well as the historical and contemporary warrior ethos in context. As a civilian researcher, I have become sensitive to how the warrior identity and warrior ethos is often used as a rhetorical tool that advances personal research and/or political agendas without taking into account the concrete day to day experiences of those who serve in the United States military. While working on a qualitative project related to combat medics, I had the privilege of collaborating with Sarah Huffman, my co-author. Sarah has enhanced my professional understanding of military medical ethics by providing rich insight into what it means to be a trauma nurse working in combat casualty care from the lived perspective.

Sarah L. Huffman

My, Sarah L. Huffman, entire military nursing career has been painted by war in Iraq and Afghanistan. As such, my focus has always been on becoming a better trauma nurse and providing the highest level of care to wounded warfighters. Wherever soldiers and marines go I want to go and be prepared to save lives. This passion for caring translated into the pursuit of higher levels of training and knowledge to save more lives on the battlefield. Therefore, I trained as a critical care air transport nurse, expeditionary critical care nurse, and ground surgical team member. Eventually I became an acute care nurse practitioner in order to perform

more invasive interventions in trauma care. Through four deployments, however, my understanding of how I was providing combat casualty care began to shift. Having the resources and skills to maintain and move mortally injured warfighters to higher echelons of care allowed me to imagine they might live because I was never required to attend their deaths. The process of passing catastrophic casualties to the next clinician enabled me to avoid confronting death and my own limitations. Eventually, I began to search for meaning in experiences where I touched death but did not see it through to the inevitable end. My trauma training, our evacuation system, and technical capabilities allowed me to rarely experience physical death, although I knew it would be the ultimate outcome in some cases. I started to struggle with the idea of not being with the warfighters at death. Later, while pursuing my PhD, I was forced to spend time in my own mind confronting how I provided care on the battlefield in relationship to death. At the same time I began working on a combat medic project with E. Ann Jeschke, my co-author. As a trained ethicist, she provided a safe place to begin to share and analyze my military narrative.

Key Terminology

Within combat casualty care, we rely on the following three terms: mass casualty, medical triage, and reverse triage. A mass casualty is an incident which medical resources are overwhelmed by the number and severity of casualties. Medical triage is differentiating injured warfighters into specific categories according to level of severity so as to allocate resources. Under normal conditions the most severely injured would receive priority of medical intervention. There are four levels of triage within combat casualty care. They are as follows: *minimal*, which refers to battlefield injuries that can be managed by an injured warfighter or battle buddy; *delayed*, which refers to battlefield injuries that are not mortal, but require eventual surgical intervention; *immediate*, which refers to battlefield injuries that will survive if given immediate life-saving medical intervention; and *expectant*, which refers to battlefield injuries that require a maximal amount of medical intervention with a minimal chance of survival. Finally, reverse triage occurs when the tactical reality of the battlefield requires that injured warfighters who can return to the fight receive priority medical treatment while those with a low likelihood of survival will receive only supportive care.¹

Within military ethics, the term “necessity” is a highly debated concept. It applies to both decisions about the legitimacy of engaging in war (*jus ad bellum*) and how war is fought on the battlefield (*jus in bello*). We understand military necessity on the battlefield to be a restrictive principle that, under certain conditions, allows commanders to forgo certain levels of restraint when attempting to achieve a particular mission. For example, if the United States military is fighting a just war and the enemy maintains a tactical advantage that threatens to overcome our forces, then it is permissible to invoke military necessity.²

The principle of military necessity factors prominently into our analysis because combat casualty care providers and commanders are bound by international humanitarian law to uphold the principle of medical neutrality. This legal ideal suggests that the most severely injured on the battlefield receive priority medical care. As such, reversing triage is intimately related to ethics of military necessity because to reverse triage means to violate the normative principle of medical neutrality. For the purposes of this essay, we will simply assume that certain tactical situations in LSCO mass casualty scenarios will require the use of military necessity as a means of ethically reversing triage in order to tactically support the military mission.³

Having discussed the key ethics terms related to our paper, we turn to discuss the key terms related to the theory we will be using to analyze the medical case, namely, narrative identity theory. This theory includes scholarship from numerous different thinkers. In general, it considers what human identity and identity formation is as well as ways in which human identity is both socially and personally shaped by the receiving, living, and telling of stories. Within this broader theory, narratives function as a mode of self and other-interpretation as well as self and other-definition. Narratives are not just self-constructed stories, they are also embedded into the socio-political context in which a person exists. They are lived through the

practice of daily habits and serve as a means of developing a unique identity that is stable across time while also being open to dynamic interpretation and change. As such, the person's life-story that encompasses his/her identity is both stable and constantly under development.

Within Paul Ricoeur's narrative identity theory, identity refers to permanence of a person's historical life-story. It is composed of three aspects of identity: the *idem*, the *ipse*, and the narrative. *Idem*-identity, or character, is self-hood that is supported by sameness. Said differently, *idem*-identity is that which supports the self to identify as self through external markers of sameness that emerge from society—the social identity. *Iipse*-identity, or kept-word, is self-hood that is not supported by sameness. It is the inner inexpressible core that marks a person as an individual and is displayed by being true to self in the context of living—the intrinsic self. *Iipse*-identity relates to “who” the self ought to be; whereas, *idem*-identity relates to “what” the self is. As such, the *ipse*-identity is the locus of the ethical self, while the *idem*-identity is the locus of the practical self.⁴ Narrative identity establishes a free representation of the self by operating as a “double gaze, looking backward in the direction of the practical field and ahead in the direction of the ethical field.”⁵ As the narrative identity of a person oscillates between the two poles of *idem*-identity and the *ipse*-identity, the person functions as both the reader and writer of his/her own identity. Consequently, the life-story of a person is both static and dynamic integrating aspects of individual (micro), cultural (mezzo), and social (macro) realities.⁶

We will rely on narrative identity theory to explore how the expectant warfighter's personal death narrative plays into his/her broader life-story both in counterinsurgency operations and how this death narrative could operate in LSCO. Having provided a brief background of our professional experiences related to combat mortality, as well as some key terms, we now turn to a medical case that serves as our exemplar for analysis.

Section Two: Medical Case from Counterinsurgency Operations

When I, Sarah, first entered the military 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. Thus, part of the evaluation during the exercise was to see if clinicians would place injured warfighters into the appropriate triage category. This evaluation presented my first opportunity to fail. The actor playing the injured warfighter scripted to die, was mistakenly triaged into the immediate category, therefore, he came to my team. Operating as part of the immediate team, I did what I do best. I fixated on saving his life using all the best practices 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. While there was a team ready to receive expectant casualties, this is not what happened. Instead my peers and I resisted putting anyone into the expectant category. In the aftermath of the exercise, I was told that there was no expectation that I should apply heroic medical care to that particular injured warfighter because he was scripted to die. Instead, I was supposed to have assessed what resources were available and how to allocate these resources to balance saving lives against returning warfighters to the battlefield. While I was told that expectant casualties should be treated with dignity, no one ever told me or demonstrated what showing dignity meant. Ensuring dignity in death was a lesson I learned only in word. 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; namely, that resources are limited, injured warfighters will die, and I am the one who is expected to and must make that determination.

The real lesson I learned in the exercise 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 because there were enough medical resources and infrastructure to equally care for everybody.

In practice, the expectant triage category ceased to exist. Care providers adopted two categories of triage: the dead and everyone else. Providers designated everyone else as those not immediately killed and then managed them with maximum personnel, technical, and aero evacuation support. It was on my fourth deployment that the loss of an expectant triage category became particularly poignant.

I took care of an injured warfighter who was hit in the chest by gun fire and knocked backwards while wearing protective armor. When he fell backwards he received multiple gunshot wounds to the groin area and up into the abdominal cavity. The medics at the point of injury valiantly attempted to control his bleeding. A forward trauma surgeon cross clamped his aorta on the way to the warfighter's first treatment facility. I received him at the Role Three facility where there was a total of three trauma surgeons, nine critical care nurses, and nine medical technicians to support the 13-bed critical care unit. When he arrived, I worked with a team of three other nurses, a trauma surgeon, a respiratory technician, and a medical technician who were solely dedicated to him at the bedside for nine hours. Another team of two nurses and a medical technician assumed care for the next nine hours before transporting him to Germany.

The injured warfighter arrived by a rotary wing and was too unstable to move from the transportation pad. Normally, this pad is removed before further care is given but my team could not move the warfighter without him decompensating. Any medically trained professional could see this young man had zero chance of survival. Even if at a major trauma center in the United States, the injuries he sustained would be incompatible with life. Our team had huge limitations by comparison. However, like all other injured warfighters in my care, I went to work with the assumption our entire team would provide heroic interventions in the form of life-saving medical care. Our team put him on a monitor and ventilator to provide maximum support. We placed an arterial line and an additional central line. The team hung blood products using two rapid infusers. Additionally, we started vasopressors to maintain his cardiovascular system. In total 40 units of blood products were transfused. We also began continuous renal replacement therapy to decrease fatal potassium levels. It was likely that if more casualties came into our critical care unit, we would not have had enough blood products to provide care without instituting a walking blood bank. As was frequently the case in Afghanistan, I never thought about resources in the moment as I fastidiously continued to provide the best possible life-saving care for this warfighter. It was only after much reflection on the meaning of "care" that I thought about the allocation of resources. A skill the military wanted me to learn in the triage exercise mentioned above.

Amidst the described controlled chaos of providing life-saving care, I kept hearing his buddy say, "You have to save him." I finally turned my attention to the warfighter's buddy and looked at this young man as he pleaded for his comrade's life. I said, "We are doing everything we possibly can." I will always remember the next moment. He said, "But you don't understand ma'am." After a pause that rocked me, he said, "His brother died in Afghanistan last year." Everything went still as if in suspended animation. The chaos around me was ongoing, but everything slowed down as I tried to process what I just heard. I was the only one to hear this declaration. Everyone else went on with their frenetic intervention desperate to do everything. After what seemed like an eternity, I heard myself say "What?" He repeated, "His brother died in Afghanistan last year."

I became even more desperate to do everything. As this new information floated through the team, the intensity rose to an unimaginable level. We were ALL desperate. No one wanted to see him die even though we were saving someone who was already dead. We were acting on the expectation that we could raise Lazarus. The team at my critical care unit stabilized the warfighter enough to put him on a C-130 aero-vac to Germany. Before leaving, the warfighter was evaluated by a flight surgeon to validate that he was medically ready for transport. Thereafter, the critical care air transport team prepared the warfighter for flight by attaching all the medical equipment and packaging medications. The critical care air transport team consisted of a critical care nurse, a respiratory therapist, and a critical care physician. Upon arriving in

Landstuhl, the warfighter was immediately taken to surgery and both of his legs were amputated. His father was flown to Germany. To my knowledge his mother, wife, and three children opted not to travel. He died a few days after arriving.

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We have intentionally left space in this paper in reverence to the warfighter’s death about whom we are speaking. We, as authors, felt it appropriate to call this reality to mind before we begin the process of dissecting this medical case for our own purpose. It is also for this reason that we mentioned our respective backgrounds at the beginning of this paper. Namely, to establish that our respective frameworks shaped our understanding of the previous medical case. We also recognize that while our interpretation may be resonant to some, it can never fully contain the true meaning of any human beings’ life-story. As such, we will attempt to take off our metaphorical “shoes” for the ground on which we are about to tread is sacred. We ask you, the reader, to engage in a self-reflective process that considers how your own background is interpreting and making meaning of this medical case.

Section Three: Counterinsurgency—Honoring the Injured Warfighter’s Human Dignity

In this section, we will consider how the injured warfighter’s human dignity is honored in counterinsurgency by exploring the following: resource allocation in reference to the concept of military necessity, the relationship of care providers to the injured warfighter, and how death is functioning in the warfighter’s life-story.

Resource Allocation

When resources are rich, there can be no invocation of military necessity because there is no imminent threat of being overrun by an enemy. In counterinsurgency, the United States Armed Forces has often maintained an overwhelming advantage. The extensive amount of medical resources available to combat casualty care providers in support of the warfighter mission contribute a great deal to this overall advantage. In the story above, there were at minimum 16 primary care providers involved in the medical care of this injured warfighter. In addition, there had to be involvement from laboratory and blood-bank personnel as well as military support services including logistics, aero-evacuation system, and family support team. The list we have just given is not comprehensive but gives a broad overview of the level of resources that were provided to one warfighter in rendering life-saving medical interventions.

When reflecting on the resources available in this case, military necessity was not operant because two-thirds of the medical resources were allocated to the care of one injured warfighter. Because the life-saving medical resources were in rich supply and readily on-hand, there was no need to allocate resources based on triage. The way we allocated resources in this medical case is prototypical of how combat casualty care was/is enacted in Iraq and Afghanistan. When medical necessity is detached from military necessity, the practical outcome is that combat casualty care is driven on the principle of doing everything possible to save the life of an injured warfighter at all costs. The irony is that death is, in some instances, as evidence by our medical case, simply prolonged. Practically speaking, the way medical resources were historically allocated in counterinsurgency also gave rise to the loss of the expectant triage category.

Combat Casualty Care Provider's Relationship to Injured Warfighter

Taking the previous medical case as the exemplar for the care provider's relationship to the injured warfighter, the reader sees how the focus is on life-saving medical interventions even in the face of certain death. The medical relationship is bonded by and emphasizes the importance of an individual warfighter as a human being, not on the collective health of the unit in support of a mission. The importance of the individual warfighter is upheld and validated by the care provider who can achieve sustainment of biological function. That a brother had recently died in war, amplified the care providers' efforts to render life-saving medical interventions even though there could be no realistic expectation that the injured warfighter would live. While the unique situation was specific to this case, common to combat casualty care in counterinsurgency is that maximum effort is provided to all injured warfighters on the hope that they will, at minimum, be returned to their families before death and, at maximum, live. This can be accomplished because of the overall low number of casualties of this type of armed conflict.

How Death Functions in the Warfighter's Life-Story

Now we turn to evaluating how death functions in the warfighter's life-story using the three levels of identity—*idem*, *ipse*, and narrative—in the context of counterinsurgency. Death as a medical reality was not an option considered by care providers in this case. In other words, death related only to the injured warfighter's biological functioning, not to his identity in the world. At all points in time where life-saving medical interventions were given, death occurred to this warfighter's narrative identity because he was unable to represent, interpret, or define the balance between his *idem* and *ipse* identity. In other words, the warfighter's life-story was immediately subsumed into the social, political, and cultural interpretation of meaning by those who tended to his biological life, but not his life-story. As such, the warfighter's narrative identity became the domain of those with whom he came into contact. Moreover, it is those individuals who were given the ability to interpret as well as narrate the meaning of death in his life-story. Since the narrative identity was no longer operant, the warfighter had no way of embracing or rejecting the various narrative interpretations that were proliferated on his behalf.

In reality, the warfighter in our medical case has become a local, state, and national military hero, without reference to who he was, how he lived, or the way he died. Without identifying this warfighter, his death narrative has been re-written and orated on Facebook, you Tube, and all types of news forums, as well as by politicians. None of these people were with him during his prolonged dying process and have no context to understand how he might have wanted his death to be remembered and memorialized. Consequently, his life-story as enshrined in a death narrative written by others at the individual (care providers), cultural (military), and social (political) levels has become the property of the American people.

Combat Casualty Care: Honoring the Injured Warfighter in Counterinsurgency

How warfighters should be honored in counterinsurgency is illustrated by the magnitude of medical resources used to render life-saving interventions. Honoring someone's life in combat casualty care operates on the assumption that biological functioning is what is of importance to the warfighter's existence. While there is virtue in giving so much medical to a warfighter who has served his/her country, what we have shown is that there are other considerations that have not been explored in relationship to honoring the injured warfighter. Specifically, expressing due honor in this fashion has the tendency to kill the narrative identity of the warfighter. Ignoring death as a potential medical outcome, paradoxically causes death to the warfighter's life-story because it does not allow him/her to participate his/her dying process. They lose their ownership of their own death narrative. The danger implicit in ignoring the warfighter's death narrative as an integral aspect of his life-story, is that his/her identity becomes susceptible to being hi-jacked for other people's purposes.

Section Four: LSCO—Honoring the Injured Warfighter’s Human Dignity

In this section, we rely on our medical case to consider how the injured warfighter’s human dignity can be honored in LSCO. As was stated in our introduction, we will be focusing on a mass casualty scenario, which implies that the number and severity of casualties overwhelm the available resources. In such an instance reverse triage would be necessary in order to allocate resources. When thinking about mass casualties in LSCO there are three main challenges predicted for combat casualty care providers: there will be very limited medical assets far forward on the battlefield, no medical infrastructure in country, and evacuation of injured warfighters will be prolonged up to 72 hours. The practical result is that injured warfighters will have to be maintained for longer periods of time in austere settings with minimal resources. Under these conditions, it is more likely that there will be a mass casualty situation, especially if experts who project casualty rates in the 1,000s are accurate. In the event of a mass casualty, military necessity could dictate reverse triage in order to return the least injured warfighters to duty. Consequently, priority in combat casualty care can no longer be placed on saving individual warfighter’s who are catastrophically injured.

Returning to our medical case, placing this injured warfighter on a hypothetical battlefield in LSCO leads to the re-emergence of an expectant category of triage. As such, this warfighter would be denied life-saving medical care for the following reasons. First, the supply and resupply of medical resources is limited by LSCO because it will be a restricted and denied environment. Second, the number of casualties would exceed the medical capabilities available on the ground. Third, the tactical reality far outweighs the life of individual warfighters. If those who can be returned to duty are not, then it would place everyone and the mission in harm’s way. Even if all of the least injured are returned to duty and medical provisions remain available, there will be no means to aero-vac severely injured warfighters out of the area of operation. In the prolonged field care environment, a catastrophic injury such as described in this medical case would not survive. Focusing care on saving his biological life would use too many additional resources that could be allocated to warfighters with survivable injuries or reserved for the next round of casualties.

This medical case clearly illustrates how honoring the injured warfighter by allocating excessive medical resources to life-saving intervention becomes impossible in the LSCO environment. As such, the relationship that implicitly morally binds the care provider to the warfighter can no longer exist in LSCO. While we recognize the loss of this particular way of honoring the injured warfighter implies a complex transition for the care provider, it is beyond the scope of this paper to delve into that ethical reality. In exploring alternative ways to honor the expectant warfighter, we return to narrative identity theory to discuss the value of embracing his/her death narrative as an integral element of his/her life-story.

How to Honor the Warfighters Life-Story by Resurrecting Death

We begin by suggesting that personal presence is the foundation of honoring the expectant warfighter in a LSCO mass casualty scenario. Recognizing that the concept of personal presence is nebulous, at best, and rhetorical, at worst, we move forward by trying to give some delineation of how “presence” can be imparted in a way that honors the expectant warfighter. To achieve this goal, a designated attendant could be assigned to the duty of caring for expectant warfighters by bearing witness to the events that surround his/her death. This duty of bearing witness would not directly focus on the immediate battlefield dynamics. Instead, the attendant who provides personal presence could attempt to embrace and interact with the warfighter’s dying process as it naturally unfolds. Antithetical to personal presence would be any attempts to direct the death in any fashion that might prolong biological life or expedite biological death.

By embrace, we mean the willingness to practice reception and acceptance in a nonjudgmental fashion regardless of what happens. We envision acceptance as an ongoing process that begins on the battlefield and evolves as the attendant attempts to make meaning of an individual warfighter’s death within the context of the attendant’s life-story. Part of the process of acceptance is recognizing that meaning making will involve

various levels of individual, organizational, and societal interpretation of the warfighter's life-story. By interact we mean the willingness to respond to symbolic gestures of the warfighter during his/her dying process. These gestures could be expressed in many ways. Some examples might be spoken words, guttural utterances, embodied responses, breathing patterns, or physical signs and symptoms. When responding to the warfighter's attempt to connect and communicate, the attendant would need to realize that the context is saturated with various layers of interpretation that lead to the development of the warfighter's death narrative. Part of meaning making and interacting involves responding to the warfighter's expressed need for palliation of pain. While this is often thought of as pharmaceutical management of pain symptoms, it could be expanded by means of attuning to the warfighters breath and engaging in synchronous breath, or placing a hand on the warfighter's body to reassure him/her. Human emotional attunement and skin-to-skin contact are especially important if pain medications are not available.

Beyond the scope of embracing and interacting with the dying warfighter, it would be beneficial for the attendant to bear witness to the context in which the death narrative occurs. Providing contextual details to the death narrative helps others who interact with the life-story of the fallen warfighter more accurately interpret and make-meaning of his/her death narrative without losing sight of her personal identity. Furthermore, it will likely help loved ones to more completely process the loss and integrate the warfighter's true life-story into their own. These are a few suggestions that we provide as a means to introduce further discussion. Our paper truly is operating as an introduction to the topic. We are eager for the reader to provide us with other insights within their worldview that might be beneficial when considering best practices for honoring the expectant warfighter in LSCO.

Conclusion

In this paper, we reflected on the broad question of how to honor injured warfighters within the limitations of a mass casualty scenario in LSCO. By analyzing a medical case, we suggest that one potential way to honor the human dignity of an expectant warfighter is to bear witness to his/her death narrative by providing a personal attendant that could offer personal presence. The goal of this form of comfort care would not only be to palliate pain, but also to embrace and respond to the dying warfighter such that his/her life-story is preserved beyond his/her biological death. We began by giving background on who we are as authors as well as the key terms used as part of our analysis. Next, we presented a medical case that served as an exemplar of how combat casualty care is currently functioning within the counterinsurgency environment. Thereafter, we compared how combat casualty care providers honor human dignity during the dying process in counterinsurgency operations and how it might be expressed in LSCO.

We now conclude by sharing some of our personal reflections about the medical case in relationship to honoring the fallen warfighter. I, Sarah, will discuss how this medical case influenced my identity as a critical care nurse. For a long time, I felt guilty for not saving this warfighter because I believed I owed his family nothing less than a son who was alive. I was deployed to keep him alive and I felt like I failed. The family had already lost one child. How do you tell this family they lost another son? Intuitively, I knew I was stuck in a terrible moral dilemma. I was tasked with keeping this warfighter alive and wanted to achieve that goal. At the same time, I knew he would die, and the right thing would be to give him a peaceful death. As a result, I ended up both medically and morally failing. I was unable to live up to what I had previously held as the central virtue of my personal identity as caregiver. To me being a healer and caregiver implies that I be able to provide the right type of medical care to the right person in the right way at the right time. Attending death, when it is the right thing to do, just like saving life, when it is the right thing to do, is the essence of practice as a critical care nurse. There were countless situations like the medical case described during my deployments in support of counterinsurgency operations. I now realize these experiences slowly closed the door on my ability to embody the identity I once maintained. Making determinations about whose death should be attended and whose should receive life-saving care was no longer a virtue I inhabited in my

practice of combat casualty care. The one thing I cling too when reflecting on this warfighter's death is that we loved him and cared for him to the best of our abilities in context to the situation. He was never alone.

What I have come to realize is that my *ipse* and narrative identities were also subsumed into a bigger more powerful *idem*-identity against which I could not stand alone. As a result, my personal *ipse*-identity that was grounded in making caring choices for the warfighter in need gave way to the pressures of combat casualty care and formed my personal identity and way of interpreting myself, others, and what it means to honor our injured warfighters. If I had been allowed to bear witness to this warfighter's death narrative, I would have first and foremost preserved my own identity. I would also have some sense of closure. Not having experienced his death narrative also causes me to continue interpreting this warfighter's story to my own ends to establish clarity in my own narrative identity. In contrast, being able to embrace his death narrative would provide context to both his *ipse*-identity as a warfighter and my own as a caregiver such that our narrative identities are mutually supporting each other's life-story in a dignified manner.

Although I have no experience with combat casualty care or the warfighter of whom we have been speaking, I, Ann, can say that this case has afforded me the opportunity to realize how often I interpret the meaning of both the warfighter's life-story and the combat casualty care provider's life-story as an American citizen in a way that fails to appreciate each person's unique perspective. One of the hardest aspects of being a civilian in this area of specialized research is knowing when my thoughts, insights, advocacy, analysis, writing, or goals are being propelled by the lived experience of those who serve in the United States Armed Forces or by my own agenda. I have become acutely aware of my knee-jerk reaction to draw out more emotional meaning from a warfighter's death or a combat casualty care provider's exposure to death than is necessary. Attempting to do "right" by these "fallen" warfighters, it is easy to say gloriously powerful or heroic things without knowing them or their struggles, weaknesses, and vulnerabilities.

While I have come to no sure conclusions about what it means to honor the warfighter in his/her death, I have become more sensitive to what I am doing in relationship to the warfighter's narrative identity as an American citizen. Unlike Sarah, whose *ipse*-identity, was transformed by her experiences of being a combat casualty care provider, my *idem*-identity has been softened as I struggle to avoid over-aggrandizing the value of individual warfighters' stories as a mere means to promote my professional career. Furthermore, I am sensitive to being overly meek and standing in socially sanctioned narratives without having the courage to speak truth to social power. This was keenly felt as I worked on this project with Sarah. Amidst our writing process, I came to realize that even working on this paper was doing violence to her story as I probed and dissected it to highlight various resources over and above her own personal emotional history.

We leave the reader with few answers. Hopefully, this project will help us all to reflect on the ways in which our lives as citizen intersect with the deaths of our warfighters who have given their lives in service of our country.

End Notes

1 E. Falzone et al., “Triage in Military Settings,” *Anaesthesia Critical Care & Pain Medicine* 36, no. 1 (2017): 43–51.

2 Craig JS Forrest, “The Doctrine of Military Necessity and the Protection of Cultural Property during Armed Conflicts,” *Cal. W. Int’l LJ* 37 (2006): 177.

3 Paul Gilbert, “Medical Neutrality and the Dilemmas of War,” in *Military Medical Ethics for the 21st Century* (Routledge, 2016), 101–112.

4 G r me Truc, “Narrative Identity against Biographical Illusion: The Shift in Sociology from Bourdieu to Ricoeur,” * tudes Ricoeuriennes/Ricoeur Studies* 2, no. 1 (2011): 150–167.

5 Paul Ricoeur, *Oneself as Another* (University of Chicago Press, 1992), 115.

6 Truc, “Narrative Identity against Biographical Illusion.”