Who's Your Enemy?: Incorporating Stories of Trauma into a Medical Humanities Course

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Abstract

This article discusses the theoretical and practical experiment of creating, promoting and co-teaching a medical humanities course: Medicine, War and the Arts at a School of Medicine in the United States from the viewpoint of the students who took the class. Specifically, it analyses how three themes emerged in students' responses to the oral, literary and visual stories of war and trauma in the course and how they revealed the subjective and ambivalent nature of all medical encounters with patients. The conclusion is that actively encouraging students to view the role of the physician through the lens of historical and contemporary trauma enables them to contemplate the difficult question, "Who's Your Enemy?" when caring for the sick and themselves.

Keywords War · Compliance · Clinical detachment

For seven years I was in charge of creating and teaching a medical humanities curriculum at a school of medicine in the United States. During their final two clinical years, all students were required to take one of the seven medical humanities courses. These were one-month seminars, always co-taught by a MD and a Ph.D. with a class size of fifteen to twenty students.¹ The courses met every weekday for three hours in a seminar-like setting. What follows is an analysis from 2014 of findings from one particular course that required students to read, to reflect upon and to discuss stories of trauma.

Amongst the offerings in the curriculum is a course titled, Medicine, War and the Arts. This interdisciplinary course focuses on artistic depictions, literary accounts, and oral testimonials of trauma from the Napoleonic era to the present. It has been co-taught by a cardiothoracic surgeon who is a retired US Army Reserve Colonel and myself (a medical historian and former trauma nurse) on a regular basis. Stories of historical and contemporary trauma appear in many guises throughout the course: as poems, paintings, diaries, recordings, films, and material

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culture. About a third of the class is dedicated to meeting with victims and/or witnesses of trauma. Guest presenters include a former battalion surgeon in Iraq, a nurse who was head of a combat hospital in Afghanistan, a retired surgeon who ran a trauma unit in Vietnam, a scientist who experienced the occupation of his street in Italy by the Gestapo as a child, a Professor of Bioethics who has researched and continues to help residents in the Fukushima Daiichi nuclear reactor disaster area, and a forensic psychiatrist who worked for the Air Force and specialized in training others for mass disasters. Readings for the course include Pearl S. Buck's short story, "The Enemy," a story set in Japan during World War II, concerning a relationship that evolves between a wounded American washed up on the beach near the home of a respected Japanese surgeon. Students also read lengthy excerpts from diaries kept by Japanese and Vietcong medics, discussed in more detail below.² Artwork by, and of, sufferers of trauma is discussed in detail, and students are required to write weekly reflections on course offerings and materials.

This article examines three themes that emerge in students' responses to the oral, literary and visual stories of trauma in Medicine, War and the Arts and how they reveal the subjective and ambivalent nature of all medical encounters with patients. First is the difficulty of accepting the fact that military physicians must treat both sides in a conflict equally (meaning the enemy might be cared for first). Students extrapolate this into discussions of the difficulty of treating all patients equally based on their medical issues when they have only limited resources available. Second, they are surprised to discover that war has devastating effects on physicians as well as on combatants and civilians (PTSD). This raises issues such as the development of cynicism and disbelief in physicians when it comes to listening to patients' accounts of trauma and the evolution of clinical detachment in medical school and beyond. Third, stories of trauma prompt students to discuss their negative experiences of caring for patients who are labelled non-compliant, leading to a debate on what exactly compliance means to doctors and patients and what this reveals about the recoding of humans into patients. The co-teachers of Medicine, War, and the Arts encourage students to connect these themes to realise that openly asking the question, "Who's Your Enemy?" when caring for the sick is crucial to the best practice of medical care.

Medicine, War, and the Arts has been offered five times at the school of medicine. The subject matter is provocative and can be off-putting initially for students. In fact the first time the course was offered, the enrollment was so low that it was cancelled. Resistance to the topic of medicine, war and the arts came from several places; some faculty questioned the use of such a course given that few of the students would become physicians in the military forces or be employed by the Veterans Health Administration.³ Others were concerned that the topic of war was not traditionally part of a medical humanities curriculum and/or might be too stressful for the students. Support for the course came from faculty who had served in the military and were now often engaged in emergency room work or as surgeons. They felt they had stories to tell and experiences to share with students. As the creator and co-teacher of Medicine, War and the Arts, I found myself defending the decision to offer it. The most powerful arguments involved pointing out that throughout the lifetimes of our students, America had been involved in a succession of serious conflicts. War and its consequences were part of their and their patients' identity. Producing discomfort, uncertainty, and reflection in our students about the theory and practice of medicine in wartime would give them insight and, hopefully, some skills in listening to the traumatic stories and memories of those they hoped to heal. Student evaluations have been consistently positive regarding Medicine, War, and the Arts in terms

of high numerical scoring and affirmative statements about the focus on trauma, the meaningful presentations, and the reflection work required.

The topics of the course include the effects of disease on armies, biological warfare, the development of ambulance and hospital services, battlefield medicine, the diagnosis and treatment of shellshock victims in the Great War, chemical warfare, the pioneering of plastic surgery, triage techniques in the Second World War, nuclear warfare, combat fatigue in Vietnam, the evolution of Post Traumatic Stress Disorder (PTSD), and mass disasters. These topics are by their very nature stress inducing, and from the first moment of class, the course directors openly discuss this and closely monitor verbal and nonverbal responses in students. Nowhere was the need for this more apparent than in the presentations and debates surrounding the evolution of triage and treatment in military conflicts.

The profession of medicine has separate and distinct privileges and obligations in the military environment. Physicians may, for example, carry weapons, but they are only to be for self defense and defense of patients. They may not be ordered to carry out activities in violation of their professional ethics. The obligation to care for the wounded, whether they be their own casualties or enemy casualties, is central to a presentation by a former frontline surgeon in Vietnam. He vividly brings to life, in a montage of graphic slides and pounding music of the era, the severity of the wounds he faced and the dreadful conditions in which he and his team operated. The presenter candidly talks about the need to treat all patients the same no matter what side they are fighting on. This often brings the physician in conflict with others in the military and is a constant source of tension.

Students struggled with the theory of why it was necessary for physicians to treat the enemy as well as their own in wartime and questioned if they would be emotionally prepared to do this. Reframing this issue as one concerning professional independence and medical autonomy within an environment of limited resources made it possible to expand the discussion into one about the common assumption that the key relationship in medicine is of provider to consumer. Incorporating stories of trauma into a medical humanities course broadens and questions this definition of healthcare as something provided by a physician and consumed by an individual.

The rawness of class discussions surrounding the ethics and morals of triage and the requirement to treat “the other side” first if their wounds were more critical were tempered with reflections from having heard from those in the field who had faced this situation. Medical immunity has been established by international codes of prescribed behaviour in wartime to facilitate impartiality in giving care – could this notion also be applied to care in peacetime?⁴ Or was it already in place in the theory and practice of medicine that the students were being exposed to in lecture halls, clinics, and hospitals? What did it mean to be a doctor first and a soldier second or a doctor first and a hospital employee second? How is medical autonomy limited by working for the military or an institution? These questions, raised by the co-directors of the course, the guest presenters, and the readings, were debated throughout the month of class. Often students spoke about the difficulty of treating all patients equally and giving care based purely on diagnosis and prognosis when resources were limited and insurance companies largely dictated treatment plans. It was a struggle to maintain clarity of purpose. This latter point was reinforced by what the students were most surprised by – the discovery that war has devastating effects on healthcare workers as well as on combatants and civilians in the war zone.

This discovery comes as students read, heard, and watched stories of trauma and understood the importance of such stories in the formation of the ethics, values, and empathy of medical personnel. They gain an understanding of nonverbal cues of distress and fatigue from

dissecting photographs and clips from documentaries of physicians working in combat zones. To further facilitate this conversation, readings included the experiences of trauma in various cultures and times. In particular, long excerpts are assigned for reading and discussion from two diaries written by doctors. The first is *Hiroshima Diary: The Journal of a Japanese Physician, August 6–September 30, 1945*. The author, Michihiko Hachiya (1903–1980) survived the Hiroshima bombing in 1945 and kept a diary of his experience. He was the Director of the Hiroshima Communications Hospital and lived near the hospital, about 1700 meters from the hypocentre of the explosion. Dr. Hachiya begins his diary with:

The hour was early; the morning still, warm, and beautiful . . . Suddenly, a strong flash of light startled me—and then another. So well does one recall little things that I remember vividly how a stone lantern in the garden became brilliantly lit . . . Garden shadows disappeared. The view where a moment before had been so bright and sunny was now dark and hazy . . . To my surprise I discovered that I was completely naked. How odd! Where were my drawers and undershirt?⁵ (1995, 1)

As buildings collapsed and a vicious wind spread the fire, Dr. Hachiya stumbled with his wife to the hospital, noting that he felt no shame in being naked but was bothered by the nakedness of others. Over the course of the next two months, he would document the treatment of massive burns and sight loss in patients, and the development of mysterious symptoms in the survivors, including hair loss, nausea, vomiting, and chronic fatigue; once he obtains a microscope, the doctor realises that low blood counts are also a factor in how profoundly sick his patients (and he and his wife) are. Students find this diary intriguing because it works on so many levels to pique their medical interest. First, it is a detective story, as Dr. Hachiya, like everyone else in Hiroshima, has no idea what the weapon is that had been used against him; some kind of poison gas was a strong contender. While we know that the sufferers have radiation sickness, the healthcare workers and patients do not. Second, there is the calmness and work ethic of Dr. Hachiya that captures the imagination of the students as they seek to put themselves in his shoes and assess how they would deal with such a traumatic event. Is the doctor by nature calm, or is it a cultural value, or is he clinically detached from being a long-time physician? Each of these scenarios is debated with students striving to understand what happens to feelings in times of trauma as empathy may be overcome by a need for efficiency or death spoken of with no hint of grief as healthcare workers persevere in caring for the victims.

To complement and contextualize the dropping of the atomic bomb, films taken of Hiroshima before and after the event are shown. These demonstrate not just the devastation and severe injuries of the survivors but draw attention to the parts of the diary where Dr. Hachiya reports getting lost in his flattened home city, the desperate search for water and containers to store it in, and the isolation of being in a disaster zone with no news. A Professor of Bioethics who researches and continues to enter the Fukushima Daiichi nuclear reactor disaster area gives a presentation on the reactions of the local populace to the disaster, including artwork and memorials. This allows for further conversations on how culture affects responses to mass traumatic events and what memories are preserved and why. As with Dr. Hachiya who went to his hospital in Hiroshima and began triage and then making daily rounds on his patients, healthcare workers near the Fukushima Daiichi nuclear reactor ran to their hospital to aid the injured rather than attempting to flee the region with their families.

The second wartime journal the students read and reflect upon is *The Diary of Dang Thuy Tram*. Tram was a Vietcong doctor who served as chief physician in field hospitals during the

Tet Offensive from 1967 until June 22, 1970, when an American soldier shot her in the head and killed her while she was walking down a jungle pathway. She was twenty-seven years old. Her diary was rescued from being thrown on a bonfire by an American military intelligence officer when his interpreter objected to its destruction. It was eventually returned to her family and was published to great acclaim in Vietnam in 2005. It is the story of an ardent young woman firmly committed to the Communist Party, the reunion of Vietnam, and to her profession, colleagues, and patients. The prose, is urgent, simple and heartfelt:

April 8, 1968: Today I did an appendectomy without enough medicine, just a few tubes of Novocain. But the wounded young soldier never cried out or yelled. He just kept smiling, to encourage me. I felt so sorry for him, because his stomach is infected. I would like to tell him, 'Patients like you, who I cannot cure, cause me the most sorrow.'⁶ (2007, 4)

Tram's voice, and her youth, optimism, and idealism, typically captivate students in Medicine, War and the Arts. She is like them in so many ways but her experiences (along with her politics) are almost unimaginable to them:

29 July 1969: The war is extremely cruel. This morning, they bring me a wounded soldier. A phosphorus bomb has burned his entire body. An hour after being hit, he is still burning, smoke rising from his body. This is Khanh, a twenty-year-old man, the son of a sister cadre in the hamlet where I'm staying. An unfortunate accident caused the bomb to explode and severely burned the man. Nobody recognizes him as the cheerful, handsome man he once was. Today his smiling, joyful black eyes have been reduced to two little holes — the yellowish eyelids are cooked. The reeking burn of phosphorus smoke still rises from his body. He looks as if he has been roasted in an oven. (142)

The unwillingness of Tram to leave the side of her patients and her desire to be politically engaged and to commit to a cause in spite of great personal sacrifice challenges medical students to consider what the broader role of a healer might be – to protect, fight, and risk physical and psychological harm. If Tram had survived the war, she would in all likelihood have the disease now known as post-traumatic stress disorder or PTSD. The historical antecedents and labelling of various conditions as nostalgia, shellshock, soldier's heart, and combat fatigue are also explained in the course.

Guest presenters discuss how patients were treated if they were diagnosed with a psychiatric disorder. They include a psychiatrist from a VA hospital who ran a mental health combat unit during the second Iraqi war. She is particularly eloquent in not just defining PTSD in terms of its symptoms but also in talking to students about how to diagnose it, through asking indirect questions, hearing what is not being said, not relying on your gut, and the importance of looking for consistency in answers over time. This conversation is pertinent to the third theme of the course, working with patients who acquire labels such as difficult, manipulative, and non-compliant and are dismissed as less worthy to receive care from a physician.

Survival skills in the combat theatre include segregating thoughts and feelings. This leads to combat stress which the VA psychiatrist described as a normal response to an abnormal situation and as different from PTSD where intrusion symptoms (triggers) last over a month and social and occupational dysfunction is constantly apparent. Students were surprised to learn that the availability of internet and satellite phones in combat zones that soldiers can regularly use to contact their families has been identified as increasing combat stress and

PTSD. The psychiatrist explained that the internal turmoil experienced by the troops when they learn of problems at home that they are powerless to solve is profound. This presentation is especially effective in provoking a discussion about the compassion fatigue, cynicism and disbelief that can develop from hearing PTSD-like narratives from patients. Do stories of trauma have any role to play in understanding why some people are dismissed as undeserving and/or non-compliant patients by doctors? When humans are recoded by physicians as certain kinds of patients, what effect does this have on their understanding of themselves and the understanding of the physicians?

As a summation of the course, I lead the students through an exercise in designing a war memorial for military physicians. They carry this out in groups of four or five and use a variety of techniques to present their work. Close to the medical school is a museum dedicated to the history and culture of the Great War. The National World War One Museum (NWWIM) was built in the 1920s as a memorial to the war. The class makes a lengthy visit to the museum to explore the relationship of the distinctive architecture of the building and the material culture it contains, to stories of trauma. Students gather ideas from the museum to add to those from class in order to design their own war memorial to physicians.

By the end of the course, students have learnt much about trauma including the derivation of the word itself. It has been transferred into the English literature without modification and means to wound; specifically, it refers to the actual experience of being wounded. Stories of trauma can open up new avenues for understanding the roles of physicians and patients and draw attention to the fact that vulnerability (another word of Latin origin derived from wound) is present in us all; we are all susceptible to physical and emotional attack and harm. Cooperatively designing a war memorial and then building a model of it prompts students to define what is worthy of recognition and to think deeply about what it means to be a physician in war. Groups of students have built dioramas, written prose or poetry, and found other ways to memorialise the professional activities of military physicians. They have drawn on all the stories of trauma incorporated into this one-month course and in particular have focused on what they have discovered about themselves as physicians in training, who already are starting to regard some patients as their enemies. They have reflected upon the concept that to be labelled as difficult and non-compliant is akin to being written off, as not only valueless to society but as an enemy to be feared and avoided, rather than as a fellow human to be protected and healed.

Endnotes

¹ Faculty members from the College of Arts and Sciences or the Conservatory of Music and Dance codirect the class with a physician from the medical school. Being able to interpret the humanities within the context of clinical practice fortifies the ability of students to comprehend patients' experiences and to understand what they themselves undergo as clinicians. Professionalism, cultural competence, self-reflective practice, and the ability to work with health care teams, is strengthened through a curriculum co-taught by humanities and clinical faculty.

² Texts include: Excerpts from Alfred Jay Bollet, *Civil War Medicine: Challenges and Triumphs*, Galen Press, 2002, and Tim O'Brien, *The Things they Carried*, Houghton Mifflin Harcourt, 2010, poems by Wilfrid Owen and Siegfried Sassoon, illustrated cases from contemporary Great War medical textbooks. Also, excerpts from Michihiko Hachiya, *Hiroshima Diary: The Journal of a Japanese Physician, August 6 - September 30, 1945*, The University of North Carolina Press, 1995, Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* Harvard University Press, 2003, Pearl S. Buck, "The Enemy," in Phyllis and Albert Blaustein, eds. *Doctors' Choice*, Wilfred Funk, 1957, pp. 40-59, and *Last night I dreamed of peace: the diary of Dang Thuy Tram*, Broadway Books, 2007.

³ The VHA is the largest integrated health care system in the United States with a network of 152 medical centers.

⁴ We discuss in detail the several relevant international agreements, from the Hague protocol in 1899, through the Geneva protocol of 1925, dealing with chemical warfare. Also the Biological Weapons Convention, signed by the United States in 1972, resulting in the US program becoming strictly defensive in nature. Students are encouraged to read these treaties, and to discuss the ethical aspects of these weapon systems. In some ways, the ethical issues for physician involvement in chemical and biological warfare are more disturbing to students than simple physician involvement in military medicine. Biological agents in particular are developed by scientists, often including veterinarians and physicians.

⁵ The Hiroshima bomb, known as "Little Boy"—a reference to former President Roosevelt, contained the equivalent of between 12 and 15,000 tons of TNT and devastated an area of five square miles (13 square kilometres). More than 60% of the buildings in the city were destroyed. Official Japanese figures at the time put the death toll at 118,661 civilians. But later estimates suggest the final toll was about 140,000, of Hiroshima's 350,000 population, including military personnel and those who died later from radiation. Many have also suffered long-term sickness and disability. Three days later, the United States launched a second, bigger atomic bomb against the city of Nagasaki. The device known as "Fat man," after Winston Churchill, weighed nearly 4,050 kg.

⁶ "The diary itself was a collection of pages sewn together with a cardboard cover, no bigger than a pack of cigarettes" (xvi). A second diary was later rescued and given to Fred Whitehurst the military intelligence officer. He took them back against army regulations to the United States. In 2005 Tram's mother and sisters, were located and the diaries returned to them. The same year the diary(ies) were published in Vietnam. To date, hundreds of thousands of copies have been sold, the book has been made into a documentary film called *Do Not Burn It* (2007) and a clinic and library in Duc Pho have been renamed War Martyr Dang Thuy in Tram's honour.

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