The art of medicine
Moral injury in time of war

The word injury derives from the Latin *injuria* meaning a wrong. Applied to both physical and psychological wounds, it is now used as a label for the impact that a moral and ethical dilemma might have on an individual’s wellbeing. Although the term moral injury is relatively recent, examples can readily be found in the aftermath of past conflicts. As the 100th anniversary of the end of World War 1 approaches, it is opportune to explore how its survivors attempted to come to terms with so much death—doctors at war like Arthur Osburn.

When a medical student at Guy’s Hospital in London, Osburn, the son of a Naval officer, volunteered to serve as a private soldier in the Boer War. Having discovered an aptitude for campaigning, Osburn returned to the UK to complete his studies and, in August, 1903, joined the Royal Army Medical Corps as a regimental medical officer, serving in India, China, and Burma. On the outbreak of World War 1, he was deployed to France with the 4th Dragoon Guards and took part in fierce, rear-guard actions from Mons through to Ypres. Despite being wounded in October, 1914, Osburn returned to France in January, 1915, where he served for a further 3 years. Promoted to Lieutenant Colonel, he was decorated in June, 1916, and again in February, 1918, when in command of an advanced dressing station. The citation to his second Distinguished Service Order declared that he had managed the “evacuation of the wounded under heavy shell and rifle fire in the coolest and most gallant manner”.

Although Osburn developed a technique of masking his emotions when in the front line, he later observed that the psychological demands of combat medicine had exercised a profound effect: “I felt a different person...this sense of change has never left me.” He characterised this as “a change of spirit, of vision, of feeling”. The task of “binding up...shattered bodies in war”, he wrote, having spent his peacetime career “urging fellows to keep fit”, led to an inevitable “sense of futility”.

Given his exposure to so much death, it could be argued that Osburn was suffering from a post-traumatic illness. However, his writings revealed a more complex picture. As a medical officer, he felt responsible for prolonging the slaughter: “it would be insincere to pretend I was not an auxiliary, an accessory to this killing”. In the post-war period, Osburn sought to resolve this upsetting moral dilemma through creativity and reparative activity. In the general election of December, 1923, he stood unsuccessfully as the Labour Party candidate for Walsall. His memoir, *Unwilling Passenger*, published in 1932, was perhaps an attempt to understand these events and expressed his sense of being swept along without agency. 2 years later, he wrote a foreword to *The Suppressed Speech*, a pacifist pamphlet published by the No More War Movement. More significant than the terrible casualties, he argued, “the real case against war rests rather upon the hideous moral declension that accompanies and follows even a successful conflict”. Likening war to an infectious disease, he concluded that “the abnormalities and hatreds that flourish under war conditions...and the encouragement of envy and malice leave marks on the national character which last longer than even the physical depletion of the nation’s manhood”. Thus, in the context of a mass war of attrition, Osburn experienced moral injury because he believed that his therapeutic skills had served to extend, rather than alleviate, the suffering of soldiers.

The term moral distress was originally used in 1984 by Andrew Jameton to describe how nurses feel when they are prevented from acting in what they believe to be an ethical manner by institutional regulations. It is characterised by shame and guilt and linked with social withdrawal and self-condemnation. Jameton also reported a longer-term phenomenon, now termed moral residue, associated with thoughts and feelings that endure after the problematic event has passed. More recently, a crescendo effect has been proposed whereby a series of patient dilemmas progressively raise both the baseline of moral residue and the level of distress experienced by each new event. Events likely to result in moral injury include direct involvement in prolonged, invasive treatment, which the professional believes is unlikely to result in a positive outcome. Moral dilemmas in medicine,
Perspectives

of course, are not a new phenomenon. What is novel, however, is the idea that such dilemmas, if they violate core values, can have an adverse impact on an individual’s mental health.

Although the concept on moral injury was originally conceived in terms of dilemmas faced by nurses, it soon attracted the attention of those working in military environments. In 1994, Jonathan Shay, a psychiatrist working for the Department of Veterans Affairs in Boston, sought to explain why some Vietnam veterans suffered from chronic post-traumatic stress disorder (PTSD) whilst others made the transition to civilian life without adverse psychological effects. From listening to their narratives, he concluded that witnessing or taking part in acts that violated deeply held beliefs about “what’s right” had an enduring impact on their mental health. “Moral injury”, Shay wrote, “is an essential part of any combat trauma that leads to lifelong psychological injury”.

As in the case of Osburn, the likelihood of experiencing death and wounding in war zones may place military personnel at particular risk of moral injury. Trauma surgeons deployed to a field hospital in Camp Bastion, Afghanistan, treated Afghan civilians and UK soldiers alike. Mark de Rond, a social anthropologist, observed that these skilled teams became exceptionally proficient at saving the lives of Afghan children who were then discharged to a local health-care system starved of basic resources, including pain relief. The thought that their expertise and protocols might in fact prolong suffering fed feelings of moral distress. Further, if their surgical intervention saved a Taliban casualty, there was no guarantee that he would return to peaceful activity; by restoring him to health, they might have been part of a broader process that contributed to the death or wounding of service colleagues.

Psychological injury suffered by doctors at war is understudied compared with research conducted into soldiers, civilians, and emergency responders. A self-report survey of UK armed forces deployed to Iraq found that medical services personnel were more likely to report psychological distress than those in all other duties, including the infantry. The finding was explained by weaker group cohesion, a high incidence of traumatic exposures (in particular aiding the severely wounded and handling dead bodies), and post-deployment experiences (returning to an environment where they were not understood or supported). Although the survey did not explicitly gather data on the incidence of moral injury, the results accord with individual accounts of doctors facing a dilemma about the value of their work in a context of conflict.

Moral injury has been proposed to explain why some veterans with chronic or severe PTSD do not fully recover with cognitive-behavioural interventions found to be effective in civilian populations. Such treatments are designed to modify an enduring sense of threat by re-evaluating thoughts and memories of trauma. It is postulated that this approach may lack the breadth to address guilt and shame related to acts of commission (such as killing) or omission (failing to prevent atrocities). Because moral injury impacts on the way that a person views themselves in relation to society, it may require a wider therapeutic narrative to restore a sense of worthiness and self-esteem. A process of self-empathy, proposed by Nancy Sherman, may allow an individual to recover a sense of lost goodness by reframing traumatic memories in a compassionate and benevolent way. Research undertaken with veterans suggests that reparative activities and rituals designed to acknowledge distress and achievements may have a therapeutic role. Treatment remains problematic, however, as there is no agreed definition of moral injury.

Although an 11-item, moral injury events scale (MIES) has been developed, it has yet to be evaluated across a range of population groups, partly because of a relatively narrow content range.

To date the emphasis has been on the treatment of moral injury suffered by military and civilian health-care populations. Less research has been done into the ways in which institutions can reduce the risk of its occurrence. Preventative proposals have included ethical fora where stakeholders can engage in debate to establish trust. For soldiers on campaign, the practicalities of organising such discussions are more challenging and moral dilemmas may have to be explored after deployment. Historically, military chaplains offered spiritual guidance in the field and confession on return from postings overseas. In an increasingly secular society, the challenge is to discover frameworks that address deep-seated and troubling thoughts. Many who have these dilemmas may not possess the opportunities or skills that enabled Osburn to write about his experiences and engage in political campaigning. Whether he fully resolved his feelings about the role of medicine in conflict is not known, although in a critique of British rule in India, Osburn acknowledged an enduring sense of guilt, writing that he had “received more than a full meed of thanks for doing a simple duty for which he was well paid…more honour than he feels he deserved”. The two World Wars played an important part in establishing the validity of psychological injury and we may now be seeing the recognition of moral wounds in the context of the recent campaigns in Afghanistan and the Middle East.

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Further reading
De Rond M. Doctors at war, life and death in a field hospital. New York: Cornell University Press, 2017