

PERSPECTIVE

Semper Fi

Pamela Grim, M.D.

A while ago, before more recent geopolitical disasters, I saw on the news that a “rapid response team” of Marines had landed in Port-au-Prince, Haiti, and I wondered whether any of “mine” were there — the recruits I see at the Parris Island Marine training facility in South Carolina. I realized my first morning here that the culture of the “Island” and the “grunts” is worlds away from my own. My first recruit-patient — an 18-year-old with pilonidal abscess — shouted “Yes, Ma’am!” or “No, Ma’am!” whenever I asked him a question. When I was his age, I was out in the streets protesting against a war. Somehow, almost unnoticed, that war has become a long time ago. What did I know about war? About as much as these kids do, I guess.

I was quickly corrected when I called him by name: you call each patient “recruit,” and he calls himself “this recruit” — no “I” allowed.

Marine basic training attempts to take a kid and turn him into a responsible, disciplined adult — in 70 training days. And it works; you can actually see the transformation from the doorway. On day 1, the recruit is lounging on the gurney as if it were a settee; on day 64, he is a taut and toned junior jarhead sitting bolt upright, a cupped hand on each knee. From the very first day, I marveled. How was this possible?

Within a few weeks, I started to get a sense of what I would see clinically. The first thing to ask a recruit is “What training day are you?” You can usually guess the final diagnosis on the basis of this information. Basic training includes 2 “intake days,” 5 “forming days,” and 70 “training days.” The kids who come into the emergency room on an intake day are usually there with slapstick stuff: someone breaks his arm stepping off the bus, another knocks himself out by running into a wall. Not a good beginning.

During the forming days (also known as “dis-orientation”), the drill instructors (DIs) introduce

themselves and make the first real demands on recruits. This is when the weeding-out process begins. The earliest to go are the kids who’ve hidden a significant medical history, anything from asthma to bad knees. These are “fraudulent enlistments.” When they get into trouble, the DIs send them to us to sort out. One kid sent in for “weakness” told me he would be fine if he could just restart his medications.

“What medications?”

“Zyprexa, Prozac, Buspar, and Ambien for sleep.”

“And they let you in here? Did your recruiter know about this?”

“My dad told me not to tell him.”

I looked at him. “What does your father do?”

“He’s career Navy.”

“And he told you not to say anything?”

The kid looked sheepish. “He thought this might make a man of me.”

That first week, the kids meet the Third Hat — usually the most junior of the DIs, who has been described as “a maniacal, sadistic, extremist psychopath whose name you, the recruit, will never forget.” His job is to ensure that once a recruit becomes a Marine, he will not crack up, become insubordinate, or “go postal” at a critical moment. Obviously, the Third Hat doesn’t accomplish this feat by being soft-spoken. And it’s because of him, I presume, that I see the other common complaints of early training — chest pain, shortness of breath, dizziness, weakness. The diagnosis invariably is “panic attack,” but these are ferocious panic attacks: heart rates of 180, respiratory rates of 50, carpopedal spasm, and — worst of all — tears. Seeing a 6-ft 4-in., 250-lb former high school football star hyperventilating, sobbing, and begging to be sent home is an unsettling experience. And what exactly should I do for him?

I have two roles here: doctor and member of the Marine training team. My usual remedies, benzo-

diazepines and reassurance, aren't really adequate for this situation. Six months from now, any one of these kids could be dying in a ditch somewhere in a country he first heard of 10 minutes before he got there. How do I help someone deal with that kind of stress?

I tell the recruit, "What you are feeling is normal fear. It's totally understandable." The recruit, say, has just come from a drill in which he's required to sit in a chamber filled with CS gas with his gas mask off for a certain period. A fair number can't handle it. They bolt out of the chamber, gasping and vomiting. We get the ones with worrisome symptoms — chest pain, severe dyspnea. Usually, it's just nerves. "It's normal to be scared," I tell the sobbing kid. "But your job now is to learn how to deal with these perfectly normal feelings. Your job as a recruit is to learn how to think even though you are frightened." Most, given time, manage to pull themselves together, but a few try to convince me that it is their constitutional right to quit basic training this very instant. (It's not.) The DI rolls his eyes. "This is the gnarliest set of recruits that has ever come through this hole," he mutters.

The DI is the catalyst that transforms recruits into Marines, and his job may have its own psychological sequelae. Recently, I saw a DI whose chief complaint was "I want to kill the recruits."

"We all want to kill the recruits," I said solicitously.

"No," he said, giving every word equally ponderous weight, "I. Want. To. Kill. The. Recruits." He buried his head in his hands. "Just send me back to Iraq. I didn't have any trouble with Iraq."

After the first few weeks, unsuitable recruits are sent home for "failure to adapt," and the long grind begins. From the endless hours of physical training, we get the traditional diseases of foot soldiers — shin splints, stress fractures, hernias, pneumonia. "Combat simulation" drills bring us shoulder dislocations, nasal fractures, and on one occasion, a mandibular fracture (LeFort type I).

The final stage of boot camp, the Crucible, is a 54-hour mental and physical gauntlet. It consists of combat exercises, forced marches, and "warrior stations." Each station is dedicated to a great Marine of the past, and as the recruits maneuver under barbed wire and over the mud flats of the Beaufort River, they are expected to relive these warriors' golden moments — Marines like Gunnery Sergeant

Dan Daily, who in 1918 led the Marine charge into Belleau Woods with the cry, "Come on, you sons of bitches, do you want to live forever?"

Oddly enough, we don't get too many injuries at this stage; most of the kids are smarter about dodging blows. What we do see are kids who are end-stage sick, with double pneumonia, grapefruit-size abscesses, appendicitis. These guys will do anything now to see this thing through. By this time, a recruit has become invested — invested in making it with his fellow recruits, invested in proving the Third Hat wrong, invested in just getting the whole damn thing over with. One kid came in with fulminating Guillain-Barré and dropped out only when he became apneic.

The final stage of the Crucible, a nine-mile hike, is dedicated to the men of Easy Company who in 1944 fought their way to the top of Mount Suribachi on Iwo Jima and planted an American flag.

"Wear the Corps' emblem with pride and honor not only on your uniform but in your heart," these new Marines are told. "Remember once a Marine, always a Marine." *Semper fi!*

Clausewitz, the great strategist on war, says there is only one means to war: combat. And with combat come casualties. The wounded from Iraq have started to make their way back home. The first we see are those with head injuries; the scuttlebutt is that we are going to see a lot of these. Most of these injuries are from roadside bombs — "improvised explosive devices" — which differ from traditional antipersonnel devices in that they shoot shrapnel and dirt up rather than the more traditional out, making a Kevlar helmet merely a bucket that collects ordnance.

Last night, a middle-aged couple came in, the wife complaining of shortness of breath. They had gotten the news that afternoon that their only son had been killed in Iraq. The man was retired from the military, and he stood ramrod straight and expressionless. But the woman was a basket case, a bottomless pit of sorrow. Her son was supposed to have come home a month ago, she told me, but his tour had been extended because of the ongoing insecurity. I called the chaplain; I talked to her for a while; I gave her some lorazepam. What else could I do?

The Marines are in the news every morning now as I get ready for work, the anchor talking about

“taking casualties” and “hearts and minds.” When I go outside, I can hear the shouts floating across the water, the young recruits out there sounding off in unison as they go out for their morning run, flat-out gung-ho at 6 a.m. The shouting sounds as if it is coming not just across the marshes but across the decades, and I swear sometimes that I can hear what they are shouting — all that Marine tough-guy talk:

Lock and load!
Ready on the left!
Ready on the right!
Ready on the firing line!

Failure is not an option!

Good to go.

From the Naval Hospital, Beaufort, Parris Island, South Carolina.

GLOBAL HEALTH

Surviving Torture

Richard F. Mollica, M.D.

The shocking, unfiltered images from the Abu Ghraib prison in Iraq have focused the world’s attention on the plight of torture survivors. Physicians in the United States are confronted as never before with the need to identify and treat the physical and psychological sequelae of extreme violence and torture. Yet this is not a new role for medical practitioners. More than 45 countries are currently suffering from the destruction caused by mass violence.¹ The 20th century has been called the “refugee century,” with tens of millions of people violently displaced from their homes. Millions of these people have resettled in the United States, and refugees, asylum seekers, and illegal immigrants now commonly enter our health care institutions.²

Despite routine exposure to the suffering of victims of human brutality, health care professionals tend to shy away from confronting this reality. My colleagues and I have cared for more than 10,000 torture survivors, and in our experience, whether in Bosnia and Herzegovina, Cambodia, East Timor, or the United States, clinicians avoid addressing torture-related symptoms of illness because they are afraid of opening a Pandora’s box: they believe they won’t have the tools or the time to help torture survivors once they’ve elicited their history.

Unfortunately, survivors and clinicians may conspire to create a relationship founded on the avoidance of all discussion of trauma. In one instance, a middle-aged Cambodian woman had had an excellent relationship with her American doctor for nine years, but he had no idea that she had been tortured.

He had had only partial success in controlling her type 2 diabetes. After attending a training session on treating the effects of terrorism after the events of September 11, 2001, the doctor asked the patient for the first time whether she had undergone extreme violence or torture. She revealed that two of her children had died of starvation in Cambodia, her husband had been taken away violently and disappeared, and she had been sexually violated under the Khmer Rouge. More recently, in the United States, her remaining daughter had been nearly fatally stabbed by a gang that burglarized her home. Since September 11, the patient had taken to barricading herself in her house, leaving only to see her doctor.

When the doctor became aware of the patient’s traumatic history, he used a screening tool (available at www.hpvt-cambridge.org/screening) to explore the effects of her traumas, diagnosing major depression. Over time, he was able to treat the depression with medication and counseling, eventually bringing the diabetes under control as well.

Thus, the effective care of torture survivors must begin with awareness. Identifying a patient who has been tortured is not like finding a needle in a haystack. Many characteristics of the patient’s background provide clues that torture may have occurred. It is estimated, for example, that 60 percent of persons who seek asylum in the United States have been tortured, as have many refugees and migrant workers. A history of torture is common in various groups that have resettled here during recent decades — for example, Cambodians and Viet-

CORRECTION

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Semper Fi . On page 4, in the left-hand column, fifth full paragraph, line 8 should have read "maxillary fracture," rather than "mandibular fracture," as printed. We regret the error. Also on page 4, in the right-hand column, second full paragraph, lines 2 and 3 should have read "who in 1945 fought their way," rather than "who in 1944 fought their way," as printed.