

Escaping the Clinic

Exposure as Care among Military Medical Professionals at War

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Abstract

This article examines exposure in the mobile reach of care in war in order to theorise exposure as care. It does so from the margins, focusing on US military medical professionals of the officer class in the Iraq and Afghanistan wars, who feel distanced from the ‘real’ war experience represented by the infantry soldier, and thus engage in practices of exposure to gain the ‘trust’ and ‘respect’ of their soldier-patients. To grasp something of the promise and perils of exposure and its everyday enactments, I analyse one army physician assistant’s accounts of secretly stealing away on combat missions and the use of an ambulation tool called ‘the walkabout’ by the military mental healthcare community. The material, operational, and tactical settings of counterinsurgency and the professional cultures of military care occupations dynamically intersect to engender specific contexts for, opportunities within, and risks associated with exposure among military elite. An examination of exposure reveals that military medical professionals recast the hegemonic authority of proximity to soldiering in terms of the ethical norms and professional values of medicine: in a word, as care.

Keywords

Military medicine, Exposure, Mobility, Care, Clinic.

Introduction

Keith¹ kicks back in his living room recliner, still dressed in his scrubs. He has hopped onto our Zoom meeting, drained by a long workday overshadowed by the uncertainties of the newly emergent COVID-19 pandemic, and he can't be bothered to change out of his second skin. Even in his state of exhaustion, it is quickly evident that Keith is a practiced and eager storyteller; accounts from his time in the US Army, first as a medic and later as a physician assistant (PA), come rushing forth. As he recounts the course of his life from near-high school dropout to junior enlisted soldier to officer keen to bend the rules, he paints himself the perpetual trickster—clever, crafty, and deeply wary of authority. But his stories catch in his throat as he begins to recall his first and only deployment serving as a PA in the early years of the Iraq war. As the insurgency expanded, their small surgical team regularly took on combat casualties at their camp's aid station in Baghdad. 'We just did a lot of trauma', he tells me. 'It was a heavy spot, a bad spot.' Because war's devastation does not respect an eight-hour workday, Keith slept at the back of the aid station in what he described as a broom closet: 'That way I could be there 24/7. We had so many MASCALs [mass casualty events], so you were never really off, but I could take a few steps and I was in the trauma room from my back room.' Living out of the back room made Keith available around the clock for injuries of any nature and scale.

But while the damages of war were literal steps away—12, to be exact—Keith spoke of an always simmering impulse to escape the aid station altogether. Against the admonitions of his superiors, Keith would get himself onto patrols by hopping onto the armoured Humvees of infantry soldiers heading off the heavily guarded camp and onto the streets of Baghdad. He grows animated as he tells me stories of going rogue. 'I actually used to jump on these Humvees and go on missions with these guys. I got into trouble for it,' he tells me, grinning. 'My ER doc would have me written up because I would jump on these missions and go out and not tell anybody.' Despite—indeed, because of—the trouble Keith's actions caused, he grew popular as the maverick 'Papa Alpha'. There were meaningful optics to a PA joining the infantry soldiers: 'I'd jump on a lot of missions because visibly, you could see it, it would lift the guys up. So, I'd come down there with my aid bag on my back, and I'd be like, "Hey y'all, you about to roll out?" And they'd be like, "Oh yes sir! Yeah, yeah!"'

For military medical providers of the officer class like Keith, exposure in the form of escaping the relative control, safety, and professional routine of the clinic has featured as a key ethic, therapeutic register, and vector of mobility in the practice

1 All names are pseudonyms. All military personnel represented in this study spoke as private individuals, not as representatives of the US Army, US Army Medical Command, or the Department of Defense.

of care in the wars in Iraq and Afghanistan.² Through exposure as strategic practice, Keith wilfully engaged the hazards and vulnerabilities, both bodily and professional, of ‘rolling out with the guys’. It required his physical movement out of the aid station, off the fortified camp, and into an urban battle space visualised as a field of pervasive and ambiguous threat (Gregory 2010); it also meant breaching the symbolic boundaries of his officer status and its disciplinary consequences. But it was precisely for these reasons that, at least according to Keith’s account, his willingness to join on missions was seen by the soldiers who became his accidental hosts as an act of solidarity: of building ‘trust’ and ‘respect’ across military rank and occupational hierarchy through an idiomatic, masculinist experience of shared exposure to combat.

In making medicine move, Keith’s exercises in exposure may appear extreme but not unfamiliar, recalling the ‘vital mobility’ of military and humanitarian medicine (Redfield 2008, 2013). The objective of medicine in war, to evoke its own spatial terminology, is to push its reach and technical capacity as far ‘forward’ to the frontlines as possible. Combat medicine is predicated, after all, on the mobility of trauma care that can meet the injured at the event of wounding; its very purpose is to administer intervention when and where medical treatment can be critical to survival. Moreover, Keith’s actions may be unsurprising given that exposure and vulnerability are central to the bodily experience of soldiers (MacLeish 2012). But unlike the combat medics he hitched rides with, as a PA ‘in the rear with the gear’, as the saying goes, Keith was not authorised to be off the installation on such missions. A highly valued asset, as one of only two PAs on their medical team of five, Keith was expected to remain on base, where his job was to be ready at all times to receive the casualties that rolled in. Yet even while providing advanced trauma medicine at the aid station—and thus, continual witness to the damages of war—Keith longed to get closer still, to extend the reach of his care to the ‘action’ itself. Keith made medicine mobile against orders to remain still.

This article examines exposure in the mobile reach of care in war. I argue that when we consider the provision of care in war’s production, we see the vital role of exposure as care, including for military medical professionals ‘in the rear’. Exposure brings care to where it is needed—in Keith’s case, to the soldiers in the Humvees, who received his trauma care skills as an upgrade to what the medics could provide. But it is also seen to improve wider provider–patient relations: by exposing themselves to soldiers’ realities—‘walking a few steps in their boots’, as

2 Military hierarchy and rank are strictly codified and determine differences including job function, level of responsibility, rules for interpersonal communication, dress, and pay. The two main ways of joining the US military—by enlisting or commissioning—mark a major division among military personnel: commissioned officers have the authority to command those under them, both officers and enlisted personnel. In the US Army, this group includes commissioned medical officers, who compose the Medical Corps, which is considered a non-combat specialty branch of the Army Medical Department.

providers often phrased it—providers *show* they care enough to be ‘out there’ with their soldiers and know them ‘on their own terms’. Exposure is thus seen by military medical professionals as having clinical importance along two interrelated dimensions of access: exposure extends the spatial and material reach of care, but it also creates strategic commensurability and contact with the enlisted, consequently facilitating patient ‘respect’ and ‘trust’. As we will see, exposure as care takes diverse forms, ranging from unauthorised escapes like those chanced by Keith, to top-down recommendations for providers to circulate outside the four walls of the clinic so as to meet enlisted soldiers ‘where they’re at’: between sets at the gym; in line at the chow hall; during night shifts up in the guard tower; and, most powerfully, on missions ‘outside the wire’.

My analysis expands upon the anthropology of care by considering care in relation to war-making. A rich body of literature in anthropology has drawn on diverse theoretical lineages and orientations to explore care as a form of moral, intersubjective practice and potentially scarce resource in situated social, institutional, biopolitical, and political economic contexts (e.g., Aulino 2019; Buch 2015; Han 2012; Mol et al. 2010; Sadruddin 2020). Scholars have traced relationships between care and violence, documenting the lived consequences of care as mobilised by the state, including the unexpected harms and exclusions produced by humanitarian and biopolitical processes (e.g., Garcia 2015; Mulla 2014; Stevenson 2014; Ticktin 2011). Anthropologists have also explored the militarisation and improvisations of care for soldiers and veterans more specifically (Chua 2020a; Finley 2011; MacLeish 2020; Wool 2015a, 2015b; Wool and Messinger 2012). Expanding on these concerns, I centre relationships between care and war-making by focusing on military providers, for whom care is the work of war.

Following the insights of scholars including Omar Dewachi (2017), Jennifer Terry (2009, 2017), and Saiba Varma (2020), I track exposure as one modality of care among military providers to illuminate complex entanglements between militarism and care at the intersections of medicine, war, and statecraft. I theorise exposure as care—as techniques made mobile across the material, institutional, and affective terrain of global counterinsurgency (Gordillo 2018), but also as relational practice by which medical providers of the officer class navigate distinctions of military caste to enhance the care they provide. Exposure as care offers one vector for illuminating what happens to ‘the clinic’ as care practices move across the hierarchical settings of military institutions and across the topography of global US military power.

Building on ethnographic work among military elites, including medical officers (Bickford 2011; de Rond 2017; Sasson-Levy and Amran-Katz 2007), I cast light on

military medical personnel of the officer class. Following these providers' lines of flight from the clinic illuminates the role of exposure in shaping the mobility, scope, and practice of care in war, but from the perspective of those who find themselves and their practice 'in the rear' and thus in some senses 'outside' the war they are in. At once central to war's production but sidelined from its hegemonic centres by virtue of their education, professional standing, and officer status, military medical professionals offer a vantage point onto the power and promise of exposure among those individuals who are distanced from a masculinist ideal of soldiering, but who also possess greater latitude to engage exposure as strategic practice and professional opportunity.

Whether officially enjoined or unofficially pursued, exposure makes demands of providers: it requires the transgression of material, spatial, and symbolic boundaries that privilege proximity to martial violence and the hegemonic masculinity of the soldier as the authoritative basis of war experience (Tidy 2016; Millar and Tidy 2017; Sasson-Levy 2003). Exposure as care thus reproduces the hierarchical masculinised politics of what is referred to in military discourses as 'ground truth', wherein 'on-the-ground' experience of combat and violence count as the only 'real' military activity and, indeed, as the 'real' itself (Pedersen 2017, 2019). Imagined and practiced in these terms, exposure can produce a masculinisation not only of the medical professional, but also of care itself.³ Focusing on providers like Keith helps us to see how the gendered basis for military authority, signified by the infantry soldier, is reproduced among non-combat medical professionals (Chisholm and Tidy 2017), who recast the politics of 'ground truth' in terms of the ethical norms and professional values of medicine: in a word, as care.

To grasp something of the lure of exposure and its everyday enactments, I draw on interviews with US Army medical professionals and published autobiographical accounts to explore why providers 'escape the clinic', and how such escapes are imagined and staged in specific material, operational, and tactical settings of the Iraq and Afghanistan wars. I begin with a discussion of Keith's stealth flights from the aid station. I then turn to an ambulation tool that the military mental healthcare community calls the 'walkabout': an informal means to establish para-therapeutic contacts with soldiers that has long been used but which has gained renewed value in the post-9/11 military. I end with a discussion of the limits providers encounter as they work to extend the reach of care. Through these accounts, I show how provider exposure seeks to informalise the patient encounter and disperse the clinic across the landscape of war's production.

3 I thank one of the reviewers for highlighting this point for me.

Methodologies

This article draws on three years of ethnographic fieldwork in the United States. The research project, based in North Carolina and Washington, DC, has been ongoing since 2018 and explores the use of psychopharmaceuticals by the US Army in the wars in Iraq and Afghanistan. Over 120 interviews, as well as several focus groups, have been conducted with Army personnel and veterans who have prescribed, personally used, or witnessed the use of psychopharmaceuticals while deployed. Prior to the onset of the COVID-19 pandemic, nearly 80 of these interviews were conducted in person in North Carolina, home to Fort Bragg, the largest Army installation by population in the world. Interviews were conducted off military installations: primarily in homes, places of non-military employment, restaurants and coffee shops, and library conference rooms. Following the onset of the pandemic, the remaining interviews, which were primarily with military medical professionals, were conducted via Zoom. Fieldwork has also included ethnographic observation at military healthcare conferences and clinical trainings, and archival research.

The arguments presented here draw specifically from semi-structured interviews conducted with 39 current and former military care providers. These providers include 12 physician assistants (PA), nine medics, and 12 mental and behavioural healthcare providers (five psychologists, two social workers, four chaplains, and one behavioural health technician). Of these providers, three medics, all but two of the PAs, and all mental and behavioural healthcare providers were still employed by the US Army at the time of interview. The military providers I spoke with were predominantly men (nine of the 12 PAs; six of the nine medics; and nine of the 12 mental and behavioural healthcare providers), although women had greater proportional representation among my interviewees than that documented by other accounts which calculate female providers as comprising approximately 16% of enlisted forces and 19% of the officer corps (Council on Foreign Relations 2020).

When I began fieldwork, I had not anticipated how exposure would feature in the experiences of deployed military care providers. The forms and stakes of exposure as care partly reflect the operational demands of the vigorous interventionist and imperial policy stance of the US. Early on in the wars in Iraq and Afghanistan, the US military mental health community, for example, re-learned earlier lessons about providing definitive treatment in situ and as 'far forward' as possible in order to enable soldiers to remain 'mission-capable' (Schneider et al. 2011). But as I came to learn, for many medical professionals reaching soldiers often meant getting to—as well as getting in with—the soldiers in their care.

The research process was likewise a process of navigating the multiple boundaries of ‘insider’ and ‘outsider’ status between myself and my interlocutors, who were often curious about how a ‘civilian researcher’—the term interlocutors often used to categorise me—had come to such a project.⁴ My connections to the military are not of the type that people are typically asking after when they ask about ‘military ties’; while I do have distant in-laws serving in the US military who deployed in the ‘war on terror’ (something I openly shared as interlocutors frequently asked), my most immediate relationship to the institution has always been through the inheritances of my parents’ experiences of war and US occupation in the Philippines (something I shared with interlocutors only very occasionally). While my embodied distance from a hegemonic white masculine ideal of soldiering came up most often with enlisted male soldiers, many saw this less as an impasse than as an opening to patiently explain aspects of military service in detail, as might an expert to a neophyte—a dynamic I understood to be shaped by my gender, class, and racial positioning, and underwritten by forms of imperial amnesia and erasure (Jacobson 1999). At the same time, because of my education and class status, military medical professionals typically related to me as a kind of professional peer. My distance from military institutions put some of my interlocutors at ease to speak freely, in ways that often did not translate neatly into recognisable pro- or anti-war positions (cf. Finley 2011; Hautzinger and Scandlyn 2014; Gutmann and Lutz 2010; Wool 2015a); others were more guarded in their discussions with me. Talking to providers about trust and exposure as care was therefore inevitably entangled with my own navigations of access, exposure, and trust in the research process, including the ways oppositional ideas of ‘military’ and ‘civilian’ shaped the relational dynamics between myself and my interlocutors (MacLeish 2021).

This process also necessarily involved navigating the ‘ambiguous space between *empathy*—often considered a prerequisite for fruitful ethnographic encounters—and *critique*—an arguable sine qua non of proper scholarship’ (Mohr, Sørensen, and Weisdorf 2021, 600, authors’ emphasis). This ambiguous space between empathy and critique is shaped by the troubled relationship between anthropology and the military, yet is also ‘always about the politics of ethnographic research more generally’ (ibid).⁵ As a medical anthropologist and scholar of US military empire, I interrogate military medicine to denaturalise ‘attachments to war’ (Terry 2017), and do so through a feminist praxis that gets closer to military actors and

4 As Kenneth MacLeish (2021, page 657, author’s emphasis) notes, the discrete categories of ‘civilian’ and ‘military’ and the otherness that the opposition between them produces not only shapes cultural politics but are ‘*constitutive of ... subjects and socialities*’, including in the production of ethnographic knowledge about military subjects, institutions, and lives. See also Lutz (2001) on how the categories of ‘military’ and ‘civilian’ are constituted through stereotyped oppositions in national culture.

5 Important in this context are debates in North American anthropology over the past decade on disciplinary engagement with military subjects, institutions, and actors, and which emerged in part from discussions of the Human Terrain System, which recruited and employed social scientists to work with military units by providing ethnographic knowledge gathered on site (McFate 2005; González 2008).

institutions to illuminate their startling complexity, tensions, and contradictions (Basham and Bulmer 2017; see also Lutz 2001, 2006, 2019). The critical potential of ethnography to move through these complexities entails what Sebastian Mohr, Birgitte Sørensen, and Matti Weisdorf have called an ‘intense empathic engagement with things military’, where ‘feeling into the other here enables understanding and, by extension, critique’ (2021, 608). This is not the ethnographic empathy often equated with compassion for our interlocutors, these authors point out; rather, it is a practice of empathy that engages research as a social process of moving through a shared sociopolitical field ‘without necessitating sympathy or compassion for these lifeworlds’ political and moral frames of reference’ (idem, 600).⁶

Rolling out and getting in

Keith’s military career did not begin with hopes of becoming a PA. Nevertheless, when he joined in 1997 as a combat medic he was quickly identified by his senior leaders as having promise and was selected for the military’s Interservice Physician Assistant Program (IPAP). Keith had only been serving for two and a half years when he finished PA school so was ‘still green to the Army’ (other Army PAs might have 10 years of enlisted time before training as PAs and then commissioning as officers) yet he felt his enlisted experience ‘helped my status with the medics a little bit’.

It was because he knew something of the pressures placed on ‘line medics’—medics who are ‘in the firefight’, treating at the point of injury—that Keith would steal rides on the Humvees. He saw his presence on those patrols as shifting the burden of care: ‘It took a lot of pressure off the line medics, because that’s a lot of stress. An 18-year-old that’s had minimal training to be responsible for 10 or 15 guys at a time for a six-hour mission?’ Stealing rides was Keith’s way of offering a helping hand to the line medics. His colleagues back at the aid station, meanwhile, saw his actions as reckless. The other PA on his team chided him once when he caught Keith heading out: ‘What the hell are you doing? You’re going to get killed out there if you keep doing this. You’ve got kids and everything.’ The risks taken in exposure have implications for those beyond the rogue PA. Yet for Keith, the boost he believed his presence and skillset gave to the soldiers in the Humvees made the risks worth taking. ‘It helped’, he told me. ‘It pumped everybody up, picked them up a notch, yeah. Because they thought they had some extra beef with them.’

6 As Kenneth MacLeish notes, such empathic engagement with military things in anthropology relies ‘neither on locating an ethically pure place to stand nor on reducing ethnography to a technical instrument innocent of politics’, but rather insists on ‘the messiness of bringing the discipline’s and the ethnographer’s own commitments and complications into view’ (2021, 657).

There was also satisfaction in breaking the rules. Keith recounted to me the time he got himself on a convoy and the company commander who was with them radioed back to the ER doc at the camp to say they were bringing back a casualty. 'And the company commander, who's standing right next to me with the mic in his hand outside the Humvee, he said, "Oh, I've got Papa Alpha out here with me and we're about to roll up. He's going to get on it"', Keith told me, a smile breaking on his face. 'And then of course the ER doc back at the camp said, "Wait a minute now. You got the Papa Alpha out there on the street?" And he said, "Yes, he's standing right here."' With a laugh, Keith recalled, 'They about took me out on that one because I didn't tell anybody.' The power of provider exposure rests in how it overturns expectations of where the medical officer 'should' be and their proper domain and scope of practice. While providing the 'extra beef' of his trauma care skills, escape from the aid station also gave Keith an unparalleled high because of its myriad transgressions. It was 'the best psychological drug there is', he insisted. 'Better than Zoloft and Wellbutrin!'

Keith's escapes from the aid stations were arguably unorthodox, and deliberately so: while volunteering for missions to experience war off the installation was not unusual among the care providers I interviewed, stealing away on Humvees against orders was, and said a lot about Keith himself, who made it clear that he staked his reputation on being the maverick. Yet his account is broadly illustrative of the admixture of obligation, strategy, and pleasure in exposure that can motivate medical professionals to gain proximity to enlisted soldiers, and the tacit value many give to escaping (and descending from) the physical and symbolic ivory tower of their officer status. While in our conversation Keith rationalised his escapes by asserting first and foremost the trauma care support he provided to the medics—indeed, it was unlikely his escapes would have otherwise been tolerated, however reluctantly, by his superiors—it was also apparent that exposure as care was bound up with the thrills of escape and of being 'in combat'. In institutional contexts where the education, professional standing, and officer status of care providers like Keith can conflict with the physical labour, stoicism, and valour that are highly valued in the classed settings of military institutions, rolling out enacted multiple transgressions officially forbidden by his officer peers but unofficially esteemed by his soldiers.

Keith's case is particularly revealing because even before his escapes he was no stranger to the damages of war. While much of his time working at the aid station was spent tending to run-of-the-mill injury and illness, monotony was punctuated by mass casualty events. Keith described a night when one of their units was ambushed and they had 65 casualties—his first real experience with trauma, he told me. As a medic, he had seen trauma in the ER working under the docs, 'But as a PA', he said, 'you own it. That's yours. You're the guy responsible.' Even while

faced with the effects of violence at the aid station, Keith longed to get closer still to violence's production: to get outside the wire.

The boundaries transgressed by escaping the aid station run deep. They are symbolic as much as they are spatial. As commissioned officers, military medical professionals like Keith take on the responsibility of caring for, managing, and leading soldiers; but they are also expected, at least theoretically, to learn and master tactical and combat skills, and thus be ready to serve as a soldier when and as needed. Yet for the majority who are based on fortified installations, medical professionals 'in the rear' are seen as relatively protected from risk in war's operations. Even as they may be intimate witness to its damages, they remain at a remove from the production of and subjection to violence that is the work of war for those like the tank armour guys Keith caught rides with. The ability of military personnel in so-called 'combat support' roles to rarely, if ever, leave the relative safety of built-up Forward Operating Bases (FOB), has generated a colourful lexicon of pejorative terms. 'Fobbit', a merging of 'FOB' and 'hobbit', is prominent among them and is meant to evoke the comforts-loving, peaceful homebodies of JRR Tolkien's novels. While FOBs can range widely in infrastructure, they are commonly provisioned with hot meals, hot water for showers and laundry, and recreational facilities, staging a culturally resonant divide between those who can remain 'inside the wire' and may be reluctant or afraid to leave the military base, and those who must go 'outside the wire'.⁷

Going outside or 'crossing' the wire has had deep significance in the 'war on terror'. Conceived and experienced as a masculinised rite of passage (Irwin 2012), crossing the wire marks in spatial terms the proximity to violence and combat that confers gendered authority and legitimacy on military personnel (Millar and Tidy 2017; Tidy 2016), motivates the work of soldiering (Brænder 2016), and structures military desires for 'the real' (Pedersen 2017, 2019).⁸ For Keith, then, crossing the wire brought him closer to the valorised, masculinised work of armoured infantrymen and to violence as combat: exposure of a different order to witnessing war's damages at the aid station. His escapes suggest that exposure as a modality of care in war can braid together complex intentions and forms of agency, where Keith's felt obligation to enhance the trauma skills of the medics was inseparable from, and indeed amplified by, the personally and institutionally meaningful act of crossing the wire. Keith thus framed his escapes as twofold acts of care: they took

7 David Abrams's ironic 2012 novel of the Iraq conflict, *Fobbit*, vividly portrays the stark divide between the strange normality of the air-conditioned, fast-food life on Iraq's FOBs and the brutality of war just yards away, while showing how the two worlds are deeply connected (Abrams 2012).

8 This hegemonic masculinist imaginary of crossing the wire is widely apparent in military accounts and serves to establish the authority to speak about—and even against—war (Tidy 2016). It is also significant to the ways others in positions at the margins of military communities, like embedded journalists and researchers, approach and claim 'insider' status. Consider the titular significance of Anna Maria Cardinali's *Crossing the Wire: One Woman's Journey into the Hidden Dangers of the Afghan War*, based on her experiences working for the US Army as a social science researcher (Cardinali 2013).

his skills out of the aid station to amplify trauma care for the soldiers out on the streets, while showing these soldiers that he cared to put himself in harm's way 'alongside' them, granting him the authority of 'flesh-witnessing' in war in the process (Harari 2009).

Keith's escapes from the aid station offer a dramatic illustration of one form that exposure as care can take among military care providers. But exposure can carry different stakes and involve dynamics of varying risk and intensity in the work of care in war. Turning from the rogue missions of a maverick PA, in the next section I explore for comparative contrast an authorised strategy for extending the reach of care in the form of what military mental health professionals call 'the walkabout'. Whereas exposure for Keith meant stealing rides on Humvees, the walkabout typically enacts more subtle forms of exposure by providers who might never leave the base.

Exposure therapy

Considered critical to the limited toolkit available to the deployed mental healthcare provider, 'the walkabout' has been touted by the military mental health community as a hallmark of frontline care (Hoyt 2020; Warner 2017). As its name suggests, the walkabout involves the walking about of providers within service members' everyday spaces in the course of their daily activities. Like fauna to be encountered and studied in their habitat, soldiers can thus be observed, as one retired Army psychologist phrases it, 'in their natural environment': 'in the motor pool, on guard towers, or while smoking cigars' (Hoyt 2020). In this way, the walkabout enables providers to monitor general troop morale and provide in situ para-therapeutic intervention to individuals and small groups. Conceived of as 'taking the treatment to the troops' (Moore and Reger 2006, 401) and a form of 'Help in Place' (Ogle et al. 2012, 1280), the walkabout quite literally brings the provider to the people, facilitating 'out-of-office casual contacts' intended to be 'less intimidating than a clinical setting' (Hung 2008, 39).

By one news account, the walkabout marks the 'new face of mental health' in the Army, where 'therapists don't wait for the patients to walk in; they go out to the battlefield to look for them' (Leung 2005). An army psychologist interviewed for the piece tells us, 'There's no credibility to sit back in a walled-off compound with concertina wire saying, "You know, let me tell you about combat stress". I have to bring the care to them, right, and I have to show willingness to go where they are' (Leung 2005). While going to where the soldiers are can, in fact, mean physically crossing the wire to reach them, for many other mental health professionals doing the work of the walkabout this crossing remains strictly metaphorical. As a means of getting close to soldiers, the walkabout more typically involves providers

circulating in the shared spaces of daily life within military installations. Mobility and presence enable providers to strike up casual conversations as an overture to care in ways that can ‘appear as a normal conversation at places like the dining hall, recreation areas, living areas or even in transport’ (Hung 2008, 39). As such, the walkabout responds to the army’s concern that soldiers tend to be reluctant to seek out the formal services of clinic-based mental healthcare because of fear of being stigmatised. In contexts where soldiers’ whereabouts and schedules are highly regimented and disappearing from work to attend appointments is quickly noticed by peers, these para-therapeutic encounters can be masked as everyday interaction, thus earning the walkabout the affectionate moniker of ‘stealth mental health’ (idem).

In its common guise as a sideline conversation at the motor pool or a check-in while lifting weights together at the gym, the walkabout enacts a form of exposure as care that is arguably far more subtle and of a different order of risk when compared with Keith’s dramatic, adrenaline-filled escapes. Even then, providers on walkabouts perform their own kind of strategic vulnerability, one that is institutionally meaningful because of the spatial and symbolic transgressions and professional risk-taking that the walkabout enacts for the purpose of enhancing care. Hailed by the profession at large as an important strategy of preventative mental healthcare for the post-9/11 military (Hoyt 2020; Warner 2017, 93–94), the walkabout makes unambiguous demands on mental health professionals to expose themselves quite literally to their soldier-patients—to let go of the familiarity, structure, and security of the procedural formalities of the clinic and venture into the improvised interactions of everyday military life. For proponents of the walkabout, the physical availability of providers enhances access to care, but it is also the willingness shown by providers to be ‘out there’ with their soldiers that is equally, if not more, essential to establishing the soldier ‘trust’ they see as critical to that care.

Being seen is critical to being trusted. The British origins of the term ‘walkabout’—which refers to an informal stroll by public officials, namely royalty, to meet and greet the public—captures the capacity of this low-tech ambulation tool for both surveillance *and* optics: it is a way of both seeing and being seen. Positioned as key to the prevention activities that mental health personnel perform in deployment, a central goal of the walkabout is to assess the troops and ‘to gather information on the current stressors, problems, morale, or the status of service members of their unit’ (Hung 2008, 39). In light of concern for the stigmatisation of mental healthcare and efforts to normalise mental health issues by the post-9/11 US Army Medical Department (Kieran 2019), the walkabout is also significant because it makes the provider visible *to* the troops and thus ‘gets members of the unit used to seeing and talking to behavioural health personnel’ (Hoyt 2020). The

walkabout thus appears as its own kind of exposure therapy, whereby soldiers are emotionally inoculated⁹ to the presence of mental health providers—and thus to the concern for mental health itself—in the everyday spaces and routines of military life.

Responsible for a large area of operation and several thousand troops during his deployment to Iraq, Captain Simpson told me about living out of his backpack for weeks at a time as he provided outreach visits to military installations ranging from large FOBs to small outposts. He described the walkabout as ‘the single most valuable tool that I have in the toolkit’ during deployment. ‘Walkabouts is very simply going to where the soldiers are’, Captain Simpson told me, ‘whether it’s in the motor pools or going to hang out at the gym with them and working out’. He emphasised the optics of being present and listening: ‘We just sit there and talk. “Hey, how are things going? How’s the food? How are you sleeping? What’s good? What’s bad? What can you control? What can’t you?” So, really just, just being there.’ He found this to be critical work to do among junior enlisted soldiers: ‘They definitely appreciate that. Because it’s rare. They just perceive this disconnect between the junior enlisted and senior leadership.’ As in the British understanding of the walkabout, part of the power of the military walkabout rests in the act of officer ‘royalty’ descending among the ranks of everyday soldiers to listen to their concerns and potentially turn them into actionable recommendations. The walkabout mobilises the power of presence.

But while he touted the walkabout as a useful tool, Captain Simpson also suggested that these interactions don’t always go as smoothly as providers would like to imagine. Describing a typical walkabout scenario, he set the scene for me. A provider might head into the dining facility one morning for breakfast, for example, and target an infantry fireteam that has just come back in from a night mission, usually easy to spot as the haggard, unslept, and unwashed. ‘You go find your folks out at one of the chow halls and then sit down, “Hey guys, can I sit down?”’ ‘Then everyone gets all quiet’, he adds, in response to which I can’t help but burst out in laughter. Captain Simpson’s serious demeanour breaks for a moment; he, too, is smiling, obviously in on this subtle crack in the clinician’s narrative that is also a crack at his own field. While the Captain eagerly identifies ‘the guys’ and joins them, there is no mutual recognition here: he is not one of their own.

Exposure involves not only vulnerabilities on the part of the provider, but also imposes the presence of the provider on others. Captain Simpson momentarily surfaced the relational and subtle gendered dynamics of the walkabout as ‘forced’

⁹ ‘Emotional inoculation’ in psychology specifically refers to the rehearsal of anxiety-producing experiences in order to alter the individual’s responsiveness to them.

encounter, including the presumptive intimacy and awkward interactions it can sometimes produce—of finding one’s infantry guys and sitting down with them, only to be shunned. It also suggests that as stealthy as ‘stealth mental health’ is envisioned to be, *who* the mental health professionals are as well as their tactics are often known to most people if not everyone living on encapsulated military installations. If walkabouts are meant to dispel stigma and increase accessibility, Captain Simpson’s comment also suggests that exposure can throw up subtle resistances, since stigma sticks to providers in their circulation out of the clinic and into the chow halls.

Off to see the Wizard

As made apparent by Captain Simpson’s bemused observation of the dampening effect that the military psychologist can have on breakfast conversation, the military mental healthcare community is acutely aware of its own stigmatisation. Professional anxieties concerning stigma and acceptance (which have been key to driving mental health professionals out of the clinic in the post-9/11 military) shape the relational dynamics of exposure. The wide circulation of mental health professionals within and across installations emerged as a key strategy in the army’s approach to combat and operational stress in Iraq and Afghanistan, where limited staff must cover wide areas of operation; but it is also expressly positioned as a strategy for professional identity remaking.

The effort to bring psychologists out of the clinic and among their soldiers must be understood in light of long-standing ambivalence toward military mental health. This ambivalence is rooted in part in the pervasive feminisation of mental health issues as ‘weakness’, and the perception of mental healthcare as contrary to strong, self-reliant ‘real men’ who can tough out any problem in the military (Dickstein et al. 2010, 227). Thus, alongside differences in education, professional status, and military class, military mental healthcare providers confront normatively gendered ideas of care quite specific to their professions when they venture into soldiers’ territory—when they presume, as Captain Simpson did, that they can chummily sit down to a meal with infantry soldiers after a night-time mission.

Ambivalence toward mental health professionals is also shaped by the nature of the administrative power they wield. Every branch of the military has its own creative monikers for military psychiatrists and psychologists, though one common across all branches of service is the largely derisive ‘Wizard,’ whose military use dates at least as far back as the Vietnam War (Bey 2006). The term refers to the titular character from *The Wizard of Oz*, a classic American film based on the children’s novel by L. Frank Baum (1900). In the military, being sent to or seeking out mental healthcare means going ‘off to see the Wizard’, a process seen as stigmatising and potentially career-ending since the Wizard has the power to make

the soldier ‘disappear’ from their unit and send them home. Rumoured to be great and powerful in the story, the Wizard of Oz turns out to be nothing more than a charlatan operating from behind a curtain—a further unflattering commentary on the authority of military mental health professionals. The walkabout is thus a way of bringing treatment to the troops as much as it is a response to institutional and professional histories of stigma and distance. Exposure signals a ‘new’ visibility of military psychologists that begins with coming out from behind the curtain.

In a collection of autobiographical accounts written by US military psychiatrists and psychologists deployed in the wars in Iraq and Afghanistan, one Navy psychologist describes how stigma in the patient–provider encounter cuts both ways: ‘Anyone who sees mental health (providers) is weak or trying to get home, and mental health providers are weird little wizards who sit in their caves before popping up to make someone disappear’ (Ritchie, Warner, and McLay 2017, 209). But he also faults psychologists themselves for perpetuating these misperceptions, since leadership and the enlisted alike are bound to distrust psychologists ‘if you hide in your office all day long’ (ibid). Casual conversations outside the clinic were key, he explains, for showing that ‘The service members who talked to me weren’t tainted or sent home. They had just had a conversation’ (ibid). With some self-consciousness, he goes on to reflect, ‘I like to think that I seemed a little less weird, or at least less mysterious, when people had seen me a few times’ (ibid).

Personal and professional desires for exposure as care drive providers out of the clinic to bring them closer to soldiers. Proximity to soldiering is valued by providers because it can make possible care interactions of new potential that may not be possible in the clinic—interactions that can call for extemporisation, flexibility, and resourcefulness. When they leave behind the structure, routine, and procedural formalities of the clinic, providers must navigate thresholds of practice as well as limits to the reach of care, issues I explore in the next section.

Thresholds and the limits to reach

There are limits to the mobility of care and thresholds that must be negotiated even when proximity is achieved: when a soldier opens up about family issues at home to the psychologist over lunch, or when the PA manages to hitch a ride without being caught. For instance, in an institutional context where documentation of the state of one’s physical or mental health can have significant implications for whether a soldier is deemed capable of performing their duties as defined by military standards, walkabouts raise questions for both soldiers and providers about what requires documentation and follow-up and what might be left as a one-off contact. Thresholds for disclosure and documentation can also shift in relation to operational context, the intensity of proximity, and infrastructural constraints.

Providers, military command, and soldiers alike continually assess what constitutes bearable risk in relation to mental health in deployed settings, where safety and vulnerability are dynamic, and where concern for the threat of suicidal or homicidal soldiers commands a significant place in military institutional response (Chua 2020a, 2020b).

The walkabout is intended to respond to widespread concern among military personnel that formal mental health encounters will lead to the initiation of a medical profile that will limit duty or compromise one's career. Unlike in a clinic appointment, detailed records of walkabout encounters are generally not kept (Reger and Moore 2007, 171). Psychiatric nurse practitioner Major Rivera told me that while on walkabouts she often left her laptop in her office to avoid suggesting the formality of the clinic, a strategy common among the other providers I spoke with. Not unlike the anthropologist who leaves the audio recorder at home, mental healthcare providers free themselves of the trappings of the clinic to open up new kinds of interaction with soldiers and thus facilitate the objectives of the walkabout. Informality, in this sense, was critical to professionalism.

Even then, providers told me the recourse to documentation is always in the backdrop. Navigating the line of what rises to the level of requiring follow-up care or documentation can be complicated. Major Rivera described to me her thought process: 'Being a provider is dynamic in the deployed setting', she said. 'So what do you choose to document, right? And at what point do you cross the threshold of treatment?' Turning to a familiar scenario from her work on walkabouts, she noted, 'Because arguably, if I sit down and I talk with someone for an hour over lunch, I mean, there may be a period where I cross into where some of this is more therapy than just friendly conversation. But am I going back into my office and find that person's record and check it? Probably not. But it all depends.' The decision of whether or not to follow up on a walkabout involves the provider taking into consideration many factors and the balance among them. A provider may consider clinical questions like whether the soldier would benefit from additional counselling or medication; practical questions of whether the soldier would have access to follow-up care at their installation or through teletherapy; and operational and administrative questions about possible impacts on the soldier's ability to do their job. Mental healthcare providers are also vital to the risk management of soldiers who present with homicidal or suicidal thoughts or behaviours. Having more information about whether a soldier has received a diagnosis or has a history of mental and behavioural health treatment can help providers discern if further follow-up or communication with military command is necessary. Navigating the threshold for follow-up highlights the many dynamic considerations providers must hold together, even in the 'low-stakes' encounter of the walkabout.

The complexities of pinning down where ‘just friendly conversation’ crosses into therapy suggests that, while the walkabout informalises the therapeutic encounter under the sign of casual concern, its boundaries can be slippery. Major Rivera’s open-ended ‘it all depends’ also suggests that the walkabout retains within it the possibility of formal intervention. Whether it is because a soldier reaches out because of problems at home or has been targeted as a ‘problem child’ in the eyes of leadership, the walkabout means to put soldiers at ease to allow them to talk. Yet, it is not untethered to the clinic. Because soldier health and welfare are tied to performance, the walkabout can bring about the ‘mix of choice and coercion’ (Edmonds 2016, 291) and even mandated care that often characterise the therapeutic trajectory of military individuals. The walkabout’s unbuttoned informality is its prized asset; yet the walkabout is just a few steps removed from the administrative and disciplinary mechanisms of the clinic itself. While the provider must be freed of the clinic to circulate among her soldiers, the soldier may not have the same agency to walk away from the walkabout.

Mobility also presents its own technical challenges. As they circulate across wide areas, conducting visits at multiple installations and with different units for weeks, even months, at a time, providers quickly learn what essentials they need to travel and live light. The expansive and fractal nature of their mobility—of ambulation among soldiers within circulation across bases—can also make the formal tracking of encounters challenging. Major Rivera explained that her and her colleagues’ threshold for documentation could depend on the whims of internet connectivity across installations and on any given day. Even if one returns from a walkabout with the intention of following up, accessing patient records to read up on a soldier’s medical history or to document the encounter could be unpredictable given glitchy connections. This thus challenges providers to discern the most pressing cases on which to follow up when they do come into improved internet access, which might only be at another installation days later. While the walkabout expands the spatial reach of circulating providers, the technological reach required for future care does not always follow in lockstep.

Like the tire that blows on a Land Cruiser, bringing mobility of humanitarian medical aid to an abrupt halt (Redfield 2013, 69–71), provider care can meet hard limits in the material and operational settings of counterinsurgency. Whereas for mental healthcare providers these limits can surface at the whim of an unreliable internet connection, for Keith these limits were quite literally defined by the unyielding metal sides of the Humvee. Describing what it was like trying to provide trauma care in the back of a side-armoured Humvee—at that early stage of the Iraq war, they didn’t yet have tanks—Keith conceded that even though his skills contributed far greater expertise than the medics could provide if he were not there, he was limited in the trauma care that he could provide out in the streets. ‘I lose a lot of my

capability by doing that. Me out in the street without all my equipment, you know? I'm kind of limited. And being in the street, and combat, and bombs, and just trying to move somebody in a Humvee, it's like a little steel compartment, you know? There's no room in those things', he said. 'So, you get a casualty, now what are you going to do? Where are you going to put them?' For Keith, who was accustomed to practicing trauma care and doing it well in the carefully laid out and well-equipped space of the trauma bay, and in coordination with a medical team he had come to work with instinctively, rolling out involved a steep trade-off: 'I've got the extra skill sets but try rolling 60 miles an hour with some dude with multiple traumas, you know?'

Even then, Keith insisted that, like a kind of talisman, his mere presence on those missions conjured feelings of added protection. 'It definitely helped the nonmedical guys, the combat guys', he told me. 'They were like, "Oh, we got the PA rolling with us, man!" They thought they were good.' In insisting on the belief of his soldier hosts, Keith described a 'magical situation' where the distinction between medicine and magic blurred (Lévi-Strauss 1963; Rivers 1924). Stealing rides was less an imposition of healing than a consensual and relational phenomenon where the efficacy of Keith's curative powers required the belief and faith of the group (Lévi-Strauss 1963). Against the hard limits of the reach of care, this magical thinking—'they thought they were good'—was only sustainable, Keith said, because the combat guys were ignorant of his diminished capabilities. 'We're talking like just tank armour guys', he told me. 'Those guys, they're probably not the brightest guys as far as realising that.' Keith's comments about the 'dumb' faith of the combat guys he hopped on patrols with reveal the importance of status and privilege in acts of exposure: while the PA's rogue missions brought his trauma care skills to the medics on the Humvees, with Keith believing to an extent in the efficacy of his techniques, it was the magical 'trick' of his officer status and the symbolic as much as the technical attributes of his amped up medical go-bag that accorded him healing power outside the wire. Not unlike the case of the sorcerer who 'fabulates' a shared reality with patient and audience (Lévi-Strauss 1963), in those stolen rides Keith mobilised social consensus among the enlisted and their faith in his status as an officer and medical professional, in a manner that projected and reproduced the social universe of military institutions—all within the cramped steel compartment of a Humvee.

Care at war

The forms of exposure explored here illuminate entanglements between care and the work of war. Care at war not only mends the injured and restores the wounded, often back to the same battlefield (Chua 2018); it also enlists and takes on the masculinist ideals and hegemonic values of war-making itself (MacLeish 2020;

Terry 2017; Varma 2020). Proximity to the work of soldiering and martial violence confers legitimacy on military experience (Pedersen 2017; Tidy 2016) and care is no exception to this. By getting to and getting in with their soldiers, non-combat military medical professionals aim to expand the physical reach of their care beyond the clinic; they also seek to legitimate themselves as soldiers. Proximity to soldiers imparts value to the care that providers give, demonstrating their willingness to walk a mile in their soldiers' boots and know them on their own terms. Provider exposure in turn fortifies the hegemony of soldiering *through* medicine, where medicine further valorises the figure of the soldier and intimacy with martial violence as its desired objects.

Forms of exposure as care can involve different stakes and dynamics of risk-taking, and often blend professional and personal motivations in the desire for intimacy with soldiering. They can also involve deep ambivalence: medical professionals desire closeness while maintaining recourse to distance. They seek to get close to and know their soldiers; yet the very privileges and hierarchical distance that they enjoy as officers are what allow them to instrumentalise exposure as care, strategic practice, and professional opportunity. For mental health professionals in particular, their 'outsider' status may sometimes facilitate the ability of soldiers to confide in them, to tell them what can be difficult or impossible to tell fellow 'insiders'. Exposure also retains within it an always-present power differential. Casual conversations in the motor pool can lead to mandated care in the clinic; infantry soldiers perceive added protection because Papa Alpha is there to help save lives, but they must also now save his.

The movement of military medical professionals out of clinics, hospitals, and aid stations also speaks to work on the spatiality and mobility of medical care and the ambiguous boundaries between the milieu of the clinic and its 'outside' (e.g., Garcia 2010; Raikhel 2016; Redfield 2008, 2013; Solomon 2020; Varma 2020). Providers' strategic exercises in exposure expand their sphere of influence and action, casting the reach of the clinic across the landscape of war's production and the hierarchies of military life. It is improvised in the unforgiving steel compartment of a Humvee by the maverick PA; it is disavowed in the unbuttoned casualness of the walkabout yet remains at a short remove in the possibility of follow-up. The clinic is elsewhere; but it is also everywhere. Exposure suggests that for military care providers, war is the clinic, and the clinic is war.

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