

CLEAR THE BEDS

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As we transition between constant military deployments and conflicts and the aftermath, we have started to address the social and human effects of this type of continuous—over 20 years—military involvement.¹ Most veterans have some association with deployment or being sent to a place that is not “home” for extended periods to serve in multiple capacities. These exposures and levels of involvement have left each of us with some impression, memory, or trauma. Each veteran has different jobs, stories, memories, and in some cases, different traumas.

The story I choose to share here covers a couple of areas of trauma; they are personal, and they are mine. Each of us has had a journey when we return, and our experiences will shape us forever. I am not the same young man that joined the United States Air Force as a medic in 1984. That is impossible. My journey started when I left a farming community life and ventured into the military during the Cold War. We were not in active conflict. We had a lot of money, based on the Reagan administration, and we “fought” from the bases where we lived.

Let me explain life in 1984 and up until 1990 and the beginning of Desert Storm. We prepared, trained, and played hard, and except for Grenada, Panama, and a few other small quick conflicts, we fought from where we were stationed. The officer and enlisted clubs were full after softball and baseball games. Over 70 percent of the people stationed at a particular base lived on that base. It was a community, and it was tight. You lived in the Air Force 24 hours a day, and we enjoyed that. What we did not do was go to training far away, get on a plane to a dangerous place, and experience things that are not natural, that press our values and morality to the maximum and give us little time to recover until we do it all over again.

In 1990 I became an accomplished emergency room medic; I was exposed to some rough sights and sounds and had tests on my beliefs and moral foundation. Then came Desert Storm, the operation to free Kuwait from an Iraqi invasion and stabilize the energy resources that run the world. We all had to change, and after six or almost seven years of service, my whole way of serving would be turned upside down.

1. A version of this article was first published as part of *When the Cows Lie Down: The Reason People Quit YOU—Their “Leader,”* (Max Fab Consulting, 2023).

As Desert Storm kicked off, I was selected to go on the first deployment with our tanker aircraft to Saudi Arabia; I was excited and wanted to do it. But I had orders to England, and because of that, I had to stay behind. This was okay with me, and that quickly changed to a one-year remote to Turkey as backfill to support the war effort in the theater. My life as a service member changed forever at that point, and I will fast forward a bit to when the exposures started for me. The journey takes you to my place and time of moral injury.

Moral injury is defined as a psychological concept that describes the psychological, social, and spiritual distress experienced by individuals who have witnessed or participated in events or situations that violate their moral or ethical beliefs or values. It is often associated with experiences of trauma, such as war, violence, abuse, and medical emergencies. Moral injury can arise when individuals perceive themselves as complicit in or responsible for actions that go against their moral compass or the moral standards of their community or society. This can result in guilt, shame, and a loss of meaning or purpose in life.

Moral injury is different from PTSD (posttraumatic stress disorder), which is a mental health condition that can develop after exposure to traumatic events. While PTSD is primarily characterized by flashbacks, avoidance, and hyperarousal symptoms, moral injury focuses more on the emotional and spiritual consequences of having experienced events that challenge an individual's values and beliefs. In my case, the journey would present itself in this form and in the form of PTSD.

After my year in Turkey, I returned to England and soon left for California. I arrived in California in mid-August, and at that time, the humanitarian relief efforts in Somalia were in full swing. Our unit was tasked with a deployment for an independent duty medical technician; this was my advanced training. It is likened to a one—person hospital—the doc, the nurse, the lab, public health and bioenvironmental, and yes, sometimes the dentist. When asked to go, I was ineligible because I only had 45 days at my new assignment. But, I was the only one that had kept his certifications current, and so if it was not me, there would be nobody. So the waiver was approved, and off I went to Somalia.

If you know the story of *Blackhawk Down* (2001) and all that it encompasses, I arrived four days after that event; we still had a hostage to recover, and the politics and decision-making based on that event were lively. I was a new father, away from home and watching our nation's political engine operate through the projections and use of us—the military.

As I watched this unfold and had my traumatic events transpire, it became the first time I doubted my conviction and role in the execution of our nation's will. The sworn oath was a thing; my internal values and morality were pressed to the maximum to try to balance the two.

There are other similar events, as my travels took me to different places, some with shooting and others with politics, that sometimes put the ultimate pressure on me. It all culminates in a couple of places, but this story is in Iraq during the surge in 2008 when I served as the senior enlisted leader for the trauma center at Balad Air Base.

I write this after eight years of thought and collaboration with my commander from that time. As these things have shaped me and I have had time to reflect, I have run the gamut of ways to handle it all and use the energy that PTSD from trauma medicine work imparts on me and how the struggle with moral injury can make us super strong or hurt us forever. When we started down the path in Desert Storm, the journey for all veterans changed. The new journey begins with what is next after service and how we handle the permanent baggage we acquired along the way. As I have shared, this is my story, and it may be similar to others'. We all have one, and all of them are real to those who own it.

Clearing the beds in a hospital is an endeavor in self-reflection.

There are times in your life when you experience something that, when you reflect on the entire event, seems unreal and, in some ways, seems almost like it never happened. Before I started to write the first word of this, I called a dear friend and one of my leaders during this extraordinary and trying time. We will call him the doc, but he was also the leader and the one who carried a tremendous burden as we made decisions of incredible magnitude. With his permission and collaboration, this story will be ours to share from our perspective as we worked through clearing the beds and preparing for what was to be a major operation during the surge in Iraq.

Clearing the beds and what it conveys is shared with you so that maybe those of us who are critical of our leaders and think perhaps we could do it better can have an appreciation for those who take on these responsibilities and for how lonely it can be when you have to make the call and then execute it.

When I grew up in a rural community, I was exposed to leaders in less traditional ways; some were farmers, and others were business owners and even a baseball coach or two—we had cops and firemen and all the elected officials around. As I watched the farmers conduct their business and daily operations, they made decisions constantly: Do you send the cow to slaughter, do you plant, not plant, sell or buy? You also decide what you can and cannot do: vacations are a dream, and supporting your kids and their growth drives specific priorities. It always amazed me how natural it seemed. These men and women would start the decision into motion and manage and lead it. Sometimes, it did not go well, but mostly it seemed easy.

When I began to lead people and manage resources with high value, I understood what goes on in a leader's mind—the lost sleep, the seeking of counsel and advice, and the reading and research that come with preparation. The constant work is done to make you the most informed and capable leader you can be before you make a decision and while you manage the dynamics that accompany change.

When my grandfather decided to move his entire farming operation from the California northern coast to the north valley, I am sure there were many conversations had, sleepless nights, and there were kids to consider (my mother would move in the middle of high school). He had to ask advice from my grandmother, but in the end, when it came time to make the decision, it was his, and all that comes with it weighed on him.

When asked how he felt about deciding to invade Normandy in June of 1944, General Eisenhower said, and I paraphrase, that the best night's sleep he got was after he decided to go—at that moment, it was up to others to execute the mission. I am sure he worried, and he definitely led and managed through the end of the war and beyond, but in this case, his weight of command was immense in that he had lots of advice and lots of data and history to work with. Still, it is a lonely existence with all that is considered, and the whole world is looking at you to make the call, set the direction, and move out. Once you start things like that in motion, there is no going back. When we were told to clear the beds in 2008, it was not done in haste, and it was not done without heartfelt and deep thought.

In the spring of 2008, we had many operations during the surge that brought unique surges to our trauma center and, at times, some profound tragic moments. One dynamic that had arisen was the enemy had started to continuously harass part of Baghdad with rockets and mortars. It would require significant operations to neutralize and eliminate the threat. This was one of those decisions I mentioned above, and I am sure one not taken lightly, as it meant that we would have significant casualties to make that happen.

This event started the domino effect in our medical world, with the military responsibilities of executing our mission portion. This would soon become a deeply dividing emotional event for leaders of a medical unit filled with people torn between the responsibilities that come with serving as both medical personnel and as military members. In this case, the core values that drive each profession would collide in a way that would involve human emotions I have never experienced before or even to this date, including during the COVID-19 pandemic.

In the situation of fighting and going to war, the medical piece is complex. An example is seen in recent intelligence reports before the Russians invaded Ukraine. One key indicator of the imminent invasion was the fact that the medical units had started to bring blood supplies to the front lines, one of those building blocks that need to be in place before you send in the tanks. In our case, as we prepared to eliminate this threat and knew there would be multiple casualties over many days, we received the order, “Clear the beds!”

Clearing the beds sounds like a lot of work that is hard and painful. In reality, in most noncombat hospitals, this would be easier than it sounds. The challenge is always the critical care beds for highly ill people. Our situation was odd and complex, and there are always a lot of emotions attached to any patient you care for, especially with the amount of skill and expertise required to keep these people alive and try to send them home to their loved ones. There were three categories of patients: Allies (American or other Allies and civilian personnel), Iraqis (indigenous men, women and children—noncombatants), and the enemy (yes, we took care of the enemy right alongside the rest).

Our American wounded were evacuated from our hospital in 24–48 hours, no matter how badly they were hurt. This was an amazing daily feat by remarkable people; we got you home to more definitive care and your loved ones. If you were an

Allied member, it was fast, but maybe not as fast as with an American, but we got you home, too. If you were indigenous, severely injured, and needed intensive care, our trauma center was almost always the best place to be, and we offered the best chance to survive and get rehabilitated. So often we had many intensive care beds full of indigenous patients, including the enemy.

These patients (people) became part of our lives, as did the assigned Soldiers, Sailors, Airmen, and Marines who guarded the enemy patients 24/7. It was common to look down the bay of patients and have three or four guards sitting at the bedside. We did it all. The healthcare in Iraq at this time was fractured, and most civilian facilities did not have the capabilities we had, and it was constantly dropping them down a level or two in care when we moved them. The goal was always to get them as healthy as possible before we moved them, mainly to the hospitals in Baghdad. This happened frequently and usually one or two at a time, and our docs took them on the helicopters to Baghdad.

We had dedicated and highly passionate professionals who were charged with these transfers. As I said we were all passionate about our patients no matter who they were. I watched and twice participated in clean-up after an enemy patient would throw urine or feces at our Airmen. Even after all that, our Airmen continued to care for each of these patients like they were the most critical persons in the room. I bet you have a bit of emotion and many questions right now—well, multiply that by hundreds, and you can get to the place I am going to take you.

The beds were cleared for a few reasons. One was because an Allied member needed a bed, and the room was made, usually through transfer. There was the clearing of the beds because we had a mass casualty, or because military planning and doctrine dictated that the beds would be empty before a major operation where many casualties were expected. Once this order is placed, it is on the hospital command staff to execute it, and the only person it falls on is the commander, the leader of the whole smash. The leader's actions and the navigation he had to make in handling what I am about to describe was no less than impressive. I do not know more than a handful of commanders in my time that would have maintained their temper, grace, and respect any better.

So, yes, we had civilians in our hospital and intensive units; some had been there for months and had multiple surgeries. We knew their names, and some had family visits. They were there so long—an odd dynamic during a war. Yes, we had the enemy as well, no visitors, but they were indeed there for a long while and well known to us. And we always had our own, getting ready to be moved to Germany and then home. We were always kind of “full.”

When the order came to clear the beds, we had some difficult decisions needed to be made and made quickly, not to mention executed with precision and expertise. We had the right people for all of this, yet we had not anticipated the added dimension of knowing what may come of the patients we had to clear. We knew the practices of the Iraqi medical systems; they were not like ours and, in this case, did not have the resources to sustain these patients. There was a high probability that after all these

months of care, these people would not survive. In the eyes of some of our team, they were convinced that this was true. Worse yet, they felt that if they participated in clearing the beds, they were, in their words, “killing them.” Things were said like “I will not participate in euthanasia.”

The emotions ran hot and quick, and there became two camps.

Remember I told you this needed to be planned and executed quickly. There needed to be more time to vote or develop elaborate alternatives. We would promptly do the normal transfer process in mass and volume. All hands on deck, as it were. Well, we had a problem. Many of the key people in that process felt that the oath that they had taken was of the highest calling in this situation, more elevated than their officership, their command position, or the direct military orders given to them. They did not want to participate and were highly emotional about it. They were in the decision stages of do I quit or not?

This is a decisive moment: the personal and professional ramifications of disobeying an order in the combat zone can be severe. You can face extreme discipline and lose an awful lot in the end. Here we are, with patients we know and a process that is not desirable, where morals, values, credo, and medical professional beliefs all collide. This is when you are defined as a leader; these are the moments when you are all alone.

My most profound personal memory of this as the chief was interacting with fellow Airmen and medical professionals who were absolutely against it. I had my orders, the boss was clear, and we needed to move out and clear the beds. We knew the potential outcomes and who might fill that bed in the next 24–48 hours: our men and women injured in the fight. As I spoke to them, some new to the Air Force, some around for a long time, and I listened to their concerns, I had mixed emotions. I am a registered nurse; I had a calling and had taken an oath. But I am an American Airman with my orders. It was a double dilemma, for sure. I felt these individuals’ passion and desire to do and prove both things.

We had to pick the best of a few bad choices, commit to it, and execute or quit. This is where leaders show their true colors, and how they shape and execute the decision that matters forever. Everyone came around to accept that clearing the beds was okay because our guys were going in them, and our orders were our orders, and disobedience is treasonous. I wish that were the case. We had congressional inquiries that lasted long after we all rotated back to the world, and we had anger, and frankly, we lost a few people in the areas of enthusiasm or commitment. They were but a few, though, because the leader did his magic. He listened, he heard, and he explained his reasoning and the mission why; he gave clear expectations and desired outcomes, ensured we had what we needed to make it happen, and had our backs and fronts when the exterior forces played into all this.

Most of all, he cared about all of us. No matter what side of the issue we fell on, he respected our beliefs and wanted us all to have some foundation after it was over to stay, not quit, and be ready for the next mission, because there is always a next mission, a next tough decision, and a next order that sounds like clear the beds we will need to be ready for.

Did we clear the beds? Yes, with military precision. Did we like what the results for our indigenous patients were? Of course not; we all wished for a better option than sending them away. Did we quit? Maybe some quit the Air Force that day and dumped the excellent attitude and commitment, but I did not see anyone quit, because the real reason to do that was more about how the leader handled it versus the actual issue. We cleared the beds, did it well, and met the mission.

The tragic part was that the major operation that drove all of this was canceled. We never received a mass casualty and never got any of our patients back. There was no way to predict that, and no way we could have taken the risk. The leadership challenge with this part of the story requires a daily commitment to what I mentioned—we were led in a way that did not produce quitters. It created future leaders, showed us an example to follow as we continued, and showed us how to make the tough call.

What is not here is the epilogue, the part where you say, “Dave, what happened to you, and how are you doing? What did you do with all this?” Well, we each have to find our path to better mental health, using time and energy in a way that provides us the ability to thrive and to find help when needed. We are sharing our superhero tactics that have been derived from our experience and journey overall. Here are some tactics for all of us to consider:

Superhero Tactic 1: Going it alone is not healthy. The damage of the journey can only be dealt with in a healthy way with help; put your ego in your pocket.

Superhero Tactic 2: Make positive energy. The energy from the injury and trauma is real, and it drives emotion and attitude. Learn to change the polarity of the energy in a fashion that makes you stronger.

Superhero Tactic 3: Attitude is everything. Take the energy and drive a positive attitude no matter what has come your way any day. Positivity drives more positivity; use it to manage the challenges.

Lessons from Clear the Beds

- Respect toward those who disagree with your direction sometimes grows new followers.
- Listening to all viewpoints can steady emotions and calm the seas.
- Setting the direction and providing clarity is a life skill in every avenue we operate in. Your team and, better yet, your family will love you for it.
- Gather data and then make the call if it is your call. If you hesitate, you may lose your teammates and your command.
- The best decision is sometimes the best of a few terrible options. Be okay with that. It will stay the same.

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- Teams succeed and fail on the back of the leader. Build a formidable team before the crisis.
- Have your people front and back, including your kids and your spouse. They need to be able to focus. **Æ**

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