Signature Injury:
An Ethnographic Study of Mild Traumatic Brain Injury in the Post-9/11 VA Health Care System

Anna B. Zogas

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Reading Committee:

Lorna A. Rhodes, Chair

Danny Hoffman

Janelle S. Taylor

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Abstract

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Chair of the Supervisory Committee:
Professor Lorna A. Rhodes
Anthropology

This dissertation is an ethnography of a politically symbolic injury: mild traumatic brain injury. It explores the dynamics of institutional mandates, clinical uncertainty, and the ideology of rehabilitative fantasies as they intersect in encounters between military veterans and clinicians in the Department of Veterans Affairs (VA) Health Care System.

Since the beginning of the wars in Afghanistan (OEF) and Iraq (OIF), combat-related traumatic brain injuries have come to signify a convergence of historically-specific wounding technologies, armoring technologies, and medical technologies. For this reason, these physiological injuries to the brain, with their cognitive and emotional consequences, are among the "signature injuries" of the post-9/11 wars. Some traumatic brain injuries are "mild" enough that they do not cause a loss of consciousness, and therefore service members who sustained them were able to continue to function at the time of injury. These "mild" injuries (also called concussions) cannot be diagnosed with imaging technology, so diagnostic evidence of the injury is reconstructed in a verbal, clinical evaluation. Since 2005, the VA has been collecting information about veterans' past head injuries through its Polytrauma System of Care, a nationwide network of twenty-five clinics specializing in traumatic brain injury (TBI) rehabilitation.

In this dissertation, I show that institutionalized techniques for collecting data about veterans' head injuries produce more than data: screening procedures provoke veterans' movement into and around the medical center, diagnostic procedures produce anxieties about permanent impairments, and clinicians ground their therapeutic interventions in the medical uncertainty that characterizes the relationship between veterans' combat-related injuries and their present cognitive symptoms. My central argument is that the TBI Clinic is characterized by intersections of multiple kinds of attention: veterans' concerns about their inability to pay attention and remember everyday things, doctors' clinical attention directed at individual patients, and institutional attention directed at the population of OEF/OIF veterans. These forms of attention correspond to multiple regimes of power (governance, control, and targeting) which operate inside the VA and in the broader social context in which the VA is located. I show how

convergences of these forms of power over individuals and populations produce paradoxes of attention in the TBI Clinic.

My conclusions are based on ethnographic data collected over eighteen months of fieldwork in the pseudonymous Western VA Medical Center, between November 2012 and March 2015. I observed the everyday operations of the TBI Clinic and interviewed veterans and VA clinicians. I contextualize my findings about clinical encounters in the TBI Clinic by drawing on ethnographies of institutions, critical trauma theory, disability studies, and theories of governmentality. From this theoretical perspective, I situate the VA's efforts to produce knowledge about combat-related mild TBI as part of a set of fantasies of war without American casualties—a fantasy whose endurance depends on veterans' physical, psychological, and vocational rehabilitation. The dissertation is at once an ethnographic depiction of clinical encounters in the post-9/11 VA, and a theoretical reflection on what it means for veterans to be at once individual patients and part of a population of people for whom the federal government has a specific responsibility.

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PROLOGUE. SAME TRUCK. SAME BOMB.

On an overcast morning in 2015 in the sprawling American city that is home to the Western VA Medical Center, I planned to meet Justin Lozier in a café.[1] I was running late, by veterans' standards. The military conditions its members to understand that "on time" means fifteen minutes early, and by this point in my fieldwork I knew that veterans maintained this habit long after they left the military. I parked my car on a residential block north of the busy boulevard where the coffee shop was located, and I texted Justin to let him know I would arrive momentarily.

[1] All veterans' and clinicians' names are pseudonyms. The name of the Western VA Medical Center, where this research was conducted, is also a pseudonym, as are the names of the various clinics and programs I describe here.

Justin joined the military when he was seventeen years old. He signed a six-year contract with the United States Marine Corps Reserves, which allowed him to go to college at the same time as he was in the military. The Marine Corps trained him as an Infantry Assaultman. When he was twenty-one years old, Justin deployed to Afghanistan, where he was injured in an explosion—not badly enough to require medical evacuation. He finished his time in combat, and three years later, as planned, he earned his Bachelor's Degree and left the Marines when his contract expired. Now twenty-six years old, Justin had come to this large city with a friend from the Marines and he was figuring out what to do next.

When I arrived at the café, I could see through the windows that Justin was sitting in one of a pair of leather armchairs, leaning forward with his elbows on his knees, his heavily tattooed forearms and calves visible under his dark green t-shirt and cargo shorts. I waved through the window as I made my way past a line of people waiting to board the city bus. Inside, Justin stood to greet me. Though he had been out of the Marines for two years, he still had an athletic frame. His dark beard was trimmed much shorter than it had been when we met at the VA clinic the week before. On his right wrist, he wore a half-inch wide flat black metal memorial bracelet, engraved with the name of a close friend who had died in Afghanistan. I apologized again for not being "on time," and we laughed about the accuracy of the punctuality stereotype and my naïveté about the military.

I set my digital audio recorder on the small round table between the two leather armchairs. Justin warned me that he speaks softly, and sometimes mumbles. I had not noticed that about him when we met week before at VA clinic, but I supposed that talking about combat in a clinical exam room was different than talking about combat in a café.

Justin and I were from the same part of the country, so we talked about that for a few minutes, and about his decision to join the Marine Corps. After a while, I asked him to tell me again about his most serious combat injury. I had already heard the story, in the clinic. Justin had been driving the armored truck. They turned left. They hit the IED. Justin was knocked out, and he woke up underneath the steering wheel. This happened in 2010.

In the VA clinic, the story seemed straightforward—he told it that way. When I asked him in the café to tell me more about it, the story was not so straightforward.

"What does the concussion part of it feel like?" I asked.

"It's a pressure," Justin said, "And I only know that because I've been around a lot of explosions."

"So, you know what the blast wave feels like?"

"Yeah. Yeah. And I've seen what bombs can do to people with just compression, without even taking shrapnel." Gazing out the large window toward the bus stop, Justin kept talking:

> We lost [my friend] in the same bomb that I hit—my truck. Same truck. Same bomb. Just different location on the truck. And it turned the inside of the vehicle pretty much upside-down. And it turned him upside-down. Not even from taking any shrapnel—just from the impact from the explosion going through the vehicle. I mean, it blew the turret gunner up and out like thirty feet in the air. [The gunner] landed like fifty feet away from the vehicle. The whole turret came out. The doors were all blown off. But, I mean, that—the same thing happened to me, but it was just less of an impact because of where he hit it versus where I hit the bomb.

Justin gave an evocative description of how a bomb (an improvised explosive device, or IED) can destroy an armored military vehicle and its passengers. However, while he spoke, I was

fixated on something else: had Justin been in the truck when his friend was killed? When Justin told his story in the clinic, I thought everyone in Justin's truck had survived. That kind of information was important for the VA doctors to carry out their task, and they always asked about it. I did not remember having heard that a friend died in the explosion. Sitting with Justin now, I wondered how I would have missed something like that. I looked down at my open notebook on my lap, stalling, hoping Justin would clarify. He did not.

Hesitant, I asked about his friend's death, "It was the same instance, though?"

"Same everything. The way bombs are characterized is poundage. So, the poundage of the explosive was roughly the same. I hit mine in the engine block. He hit it more underneath his side of the truck."

"And the engine block protected you?"

"Yeah." He paused. Solemnly, he said, "I was just luckier, I guess."

The basic order of events that Justin had just described was unclear to me. I was familiar with veterans talking about bombs in terms of poundage, but precisely where in the truck was the engine block was located? If Justin had been the driver, where in the vehicle had his friend been? Were they in the same truck? Maybe they had been in different trucks in the same convoy? I did not want to ask these questions about logistics and timing and the location of engines. However, I did want to know what Justin meant when he said, "Same truck. Same bomb."

I asked again, "It was the same time—like at the same moment?"

This time, Justin read between the lines and answered the question I was not asking.

"Oh, no. No. Mine happened in November. His happened in February. But, I mean, to see what it did to my truck and what it did to his truck, it was just… 'Cause the whole front of my engine—the whole front was gone. And that's just the inside. What happened to his…"

Justin didn't finish this sentence. He may have been thinking about what happened to his friend's truck, or his friend's body. Probably both.

At last, I understood that Justin was comparing two different explosions that occurred four months apart. Two nearly identical bombs were detonated under two nearly identical trucks, but they *were not* the same bomb or the same truck. Justin had been lucky to survive a bomb of similar size that his similar truck had hit in a slightly different way. The nearly identical events had entirely different outcomes.

However, the two explosions *were* the same enough that knowing what happened to his friend gave Justin insight into what he, himself, had experienced. What happened to any other Marine could have happened to Justin, and he emphasized the sameness of these two events to

"Above and Beyond" (2001). Image courtesy of the National Veterans Art Museum.

such an extent that he spoke of the tucks and the bombs as if they were one: same bomb, same truck, same everything. Collapsing the two events recalled a military context in which everything was organized to be interchangeable, to eliminate confusion—a context in which two bodies, two trucks, and two bombs come to seem as if they are the same bomb and the same truck. Justin's story—and my misunderstanding—play with generalizability, standardization, multiplicity, and singularity. Bodies, bombs, trucks, and events may be merged together and pulled apart in different ways by different people at different times, depending on what they are trying to know, and how they ask about it.

In Chicago, a piece of art hangs in memorial to US servicemembers. "Above and Beyond" (2001) is made of 58,307 hand-stamped replicated dog tags suspended from the ceiling in a 13-foot-by-34-foot rectangle. The silver dog tags bear the names of each American soldier killed in combat in the country's war in Vietnam.[2] In the installation, a single black dog tag memorializes all those who died—not in combat, but from conditions related to service during the Vietnam War. As the dog tags sway and rotate on the wires from which they hang, they make a nearly inaudible metallic clinking sound, like wind chimes, but very faint.[3]

[2] If a similar memorial were made to memorialize those killed in action during the post-9/11 wars in Afghanistan and Iraq, it would contain 6,910 dog tags (US Department of Defense 2017). Or, perhaps the dead would be memorialized with 6,910 of the black metal cuff bracelets that young veterans like Justin Lozier wear on their wrists, etched with friends' names, dates, and location of death.

[3] I saw this piece while the National Veterans Art Museum, in Chicago, was under renovation in the summer of 2012. The piece was not displayed in the museum's temporary gallery space, and I climbed through ribbons of yellow construction tape to view it in its original location. Under construction, the building's atrium was dark and empty, which enhanced my auditory experience of the piece.

Justin's story paired, with this piece of art, can be read as a metaphor for the larger institutional context in which VA clinicians and veterans encounter each other. The VA is concerned with veterans as a population; clinicians are concerned with veterans as individuals. Thus, veterans who engaged with the VA were continuously brought into the larger institutional project of generating information about the nationwide population of veterans to which they belong. Encountering the installation of dog tags, the viewer's focus shifts between scales: we can see that the group is a set of individual dog tags, but we can also see the mass of them as the undifferentiated whole of the population.

"Above and Beyond" (2001). Image courtesy of the National Veterans Art Museum.

"Above and Beyond" is reminiscent of The Vietnam Veterans Memorial in that it names each of the deceased. However, there is a significant difference between the two memorials. The surface of The Memorial Wall in Washington, DC is etched with names of the deceased, but the

names do not constitute the wall. By contrast, the dog tags of "Above and Beyond" are clearly isolated objects that come to appear as if they are constitutive of one larger object—the hanging rectangle shape of the installation. The larger object is sometimes illusory, as when the viewer becomes aware of each dog tag swaying and spinning in a slightly different current of air.

"Above and Beyond" (2001). Image courtesy of the National Veterans Art Museum.

In what follows, I describe individual veterans who use the services at the Western VA. In one sense, they are patients whose individual needs are addressed by VA doctors. They were "blown up," as they say, in explosions caused by bombs and rocket-propelled grenades in Afghanistan and Iraq, and their combat-related experiences shaped their individual post-military health care needs. At the same time, as Justin's story demonstrates, the explosions were similar—IEDs were a known strategy used in wars that went on for over a decade. Thus, in another sense, the veterans at the TBI Clinic had similar experiences that together represent one of the "signature injuries" of the wars: mild traumatic brain injury. Veterans' disparate individual experiences are held together by the symbolism of the "signature injury," and together they constitute a population of veterans for whom the federal government is responsible. This dissertation concerns processes that occur between scales, and the tensions that arise when a single institution is responsible for intervening across scales.

INTRODUCTION

> *Traumatic brain injury:* A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force.
>
> VA/DoD 2016a

> *Mild traumatic brain injury:* A physiological disruption of brain function as a result of a traumatic event as manifested by at least one of the following: alteration of mental state, loss of consciousness […], loss of memory or focal neurological deficit, that may or may not be transient; but where the severity of the injury does not exceed the following:
> - post-traumatic amnesia for greater than 24 hours […],
> - loss of consciousness is less than 30 minutes.
>
> American Congress of Rehabilitation Medicine 1993

> *Concussion:* The terms "mild traumatic brain injury" and "concussion" are used interchangeably.
>
> VA/DoD 2016a

This is an ethnography of a politically symbolic injury: mild traumatic brain injury. Mild traumatic brain injuries (concussions) have become associated with the asymmetric post-9/11 wars in which insurgency movements used homemade weapons like improvised explosive devices against professional armies. Bomb-resistant armored vehicles reduced American service members' deaths and major injuries, but could not prevent concussions. Although they are not

exclusively combat injuries, when concussions result from combat they signify an historically-specific confluence of wounding technologies, militaries' armoring technologies, and rehabilitation technologies. For this reason, concussions are among the "signature injuries" of the wars in Afghanistan (Operation Enduring Freedom [OEF]) and Iraq (Operation Iraqi Freedom [OIF]).

The United States Department of Veterans Affairs (VA) is the federal institution responsible for the rehabilitation of disabled military veterans. This institutional responsibility, and the political weight assigned to traumatic brain injuries as "signature injuries" of war, has resulted in federal policies requiring that veterans' histories of concussions be documented and their treatment tracked. Within the nationwide VA Health Care System, a network of specialized traumatic brain injury clinics was created to carry out this work. I conducted ethnographic research in one such clinic.

In this dissertation, I will show that the clinic is characterized by paradoxes of attention, and I will argue that these paradoxes are evidence of intersecting forms of power that are exercised through the VA. Whereas institutional spaces like hospitals have long been associated with containment, social theorists now observe new modes of power that do not depend on discipline and instead work by tracking people as they move through the world. These more fluid and flexible modes of power are governmentality (Foucault 2007; Miller and Rose 2008), security (Foucault 2007), control (Deleuze 1991), and targeting (Chamayou 2014). My research points to the ways in which these coexisting modes of power—particularly control and targeting—shape the experience of veterans and clinicians in the context of an institution charged with responding to the wars of the post 9/11 era.

COMBAT-RELATED MILD TRAUMATIC BRAIN INJURY

Like other physical injuries, a traumatic brain injury (TBI) is an event. More precisely, it is two events: one occurs outside the body, and one within. A traumatic brain injury occurs when the body encounters an external force, and the force causes a physiological disruption in brain function. A person might fall and hit their head, be in a motor vehicle accident, be struck by an object, shot with a gun, or have their skull fractured or penetrated. Alternatively, a person may encounter a more diffuse external force, like rapid acceleration/deceleration or forces generated by explosions or "blasts" (VA/DoD 2016a). Combat-related traumatic brain injuries occur under an equally diverse array of conditions, as when service members fall from ladders or towers, hit their heads on the interior of military vehicles when they are violently shaken by explosions underneath, or when they are hit by the "walls of air" emanated by bomb explosions.

In the post-9/11 wars, improvised explosive devices (IEDs) were one of the most significant dangers to American service members. The bombs are sometimes referred to as "homemade," and they are made with such materials as fertilizer, plastic jugs, and scrap metal (Mundey 2015) In Iraq in 2007, IEDs accounted for half of American combat deaths and injuries and they accounted for 60 percent of American and coalition deaths in Afghanistan between 2003 and 2014 (Mundey 2015, 182).

One of the strange features of traumatic brain injuries is that they are a problem because people survive these events. This is true for head injuries that are not combat-related, as well. Sociologist David Webb (1998) observes that traumatic brain injury is a "revenge" on modern times because the injury is caused by modern machinery and people's survival is caused by modern medicine. In a military context, traumatic brain injuries also highlight wounding technologies, medical technologies, and protective technologies insofar as traumatic brain

injuries are indicative of the US military's successes as a "high-tech force" (MacLeish 2013, 5). By 2011, the US military had officially recorded that 31,625 service members had been injured in IED explosions, and 28,697 (over 90 percent) had survived (Wool 2015, 19). As anthropologist Kenneth MacLeish notes, all service members' injuries "are the product of the strategy and tactics that placed the soldier in the target area and the protective gear that kept the soldier alive and in so doing subjected him to injuries that he would not otherwise have lived to endure" (MacLeish 2013, 12). According to this logic, traumatic brain injuries in particular are the product of an innovation called the "MRAP"—mine-resistant ambush-protected vehicle. In 2007, these armored trucks were introduced in Iraq to replace the much more vulnerable Humvee. They have a "V-shaped hull to dissipate the force of the blast to protect troops from IEDs" (Mundey 2015, 183). In this sense, mild TBI signifies not only the aggression of the "enemy," but the US military's technological, strategic, and economic capacities to protect its personnel.

The Department of Defense's current estimates suggest that up to ten percent of members of the military deployed after 9/11 have had traumatic brain injuries (of all severities) (Cifu et al. 2013). VA data suggests, similarly, that seven percent of its users from this new generation of veterans have been diagnosed with a traumatic brain injury (Taylor 2015; Defense and Veterans Brain Injury Center 2017). A very small number of those people had severe TBIs like, for instance, Shurvon Phillip, a Marine who was airlifted out of Iraq after an explosion in 2005:

> In the explosion's aftermath, Shurvon was airlifted to the American military's hospital in Landstuhl, Germany, and then to the National Naval Medical Center in Bethesda, Md. [...] By that point a portion of the left side of his skull had been cut away to relieve the pressure of the casing of bone against his swelling brain

(Daniel Bergner, "The Sergeant Lost Within", *The New York Times,* May 25, 2008).

Severe brain injuries like Phillips' are profound and life-threatening injuries that involve an open head wound, such as a skull fracture or a bullet wound. The most severely injured service members were brought back to the US to be treated at military medical centers (for ethnographic analyses of their rehabilitation, see: Messinger 2010a; 2010b; Wool 2015). However, by contrast to these life-threatening head injuries, most American service members' injuries would be categorized as "mild." An often-cited figure is that eighty-two percent of all combat-related traumatic brain injuries were mild traumatic brain injuries, which the Department of Defense estimates to have affected around 297,000 individuals (Defense and Veterans Brain Injury Center 2017).

Like all traumatic brain injuries, mild traumatic brain injuries (mild TBI) are events. What makes the injury "mild" is the nature and duration of the event that occurs within the body—the change in consciousness. A brain injury is called "mild" when the memory loss, alteration of consciousness, or post-traumatic amnesia is of relatively short duration (American Congress of Rehabilitation Medicine 1993). Mild TBI is also referred to by the more familiar term "concussion." Thus, it is possible to imagine how in the chaos after an explosion in a combat zone, these injuries could be plausibly overlooked or service members may not even recognize themselves as injured at the time.

Though these injuries are called "mild" and a concussed soldier or Marine could perhaps keep functioning in the aftermath of an explosion, the injury is not insignificant. Symptoms include headaches, irritability and mood swings, musculoskeletal pain, and veterans report troubling moments of feeling like they have "spaced out" and an inability to remember things in

everyday life (such as items on a grocery list, topics studied in college classes, and doctors' appointments).

Even when the injury has just happened, its effects cannot be detected with brain imaging, and a defining characteristic of mild TBI is that brain scans yield normal results. The cellular brain damage caused by concussions does not appear on computed tomography (CT) or magnetic resonance imaging (MRI) scans, and it is unclear how long the effects of mild traumatic brain injuries last. Furthermore, concussions cannot be cured. Doctors sometimes compare brain injuries to broken bones to illustrate this point. For instance, a broken bone cannot be cured with medicine. The bone can be set, the person's pain can be treated, but the injured bone heals on its own. Likewise, doctors can treat the symptoms caused by brain injuries, but they cannot directly intervene at the level of brain cells—brain cells heal (or don't heal) on their own. Therefore, mild TBI is an invisible, incurable injury, experienced by American service members who were protected *enough* to survive explosions and continue doing their jobs, finish their deployments, and leave the military when their contracts expired.

THE SIGNATURE INJURY MATRIX

In American medical discourse, mild TBI has become known as a "signature injury" of the post-9/11 wars. Generally, the term "signature injury" describes wounds sustained by American service members that are common or symbolic in a period of warfare. Gender scholar Jennifer Terry writes that when a war wound is discursively elevated to the status of a "signature injury" it "brings to light a matrix of dynamic elements: weapons, targets, physical locations, bodies, medical tactics, diagnostic terminologies, and histories" (2009, 206). The injury itself comes to signify the matrix of fighting, wounding, and healing:

> The wound is a kind of signification that can be read or interpreted to offer narrative accounts of histories of weaponry, of clashes over power, of bodily vulnerability, and of the elaboration of medical practices (Terry 2009, 206).

In the case of mild traumatic brain injury, specifically, the matrix is constituted by the dynamic interaction of bombs buried underneath and beside roads in Afghanistan and Iraq and the people who detonate them, American soldiers, and the elaborate armoring technologies that the US military uses to protect its personnel.[4]

Advancements in wounding technologies produce new kinds of injuries, which in turn, inspire doctors to create new technologies of healing (Terry 2009, 206-209). Therefore, every modern war has signature injuries because wars exist in mutual provocation with medicine. During the Napoleonic Wars after the French Revolution (1803–1815), muskets mounted with bayonets produced battlefields full of bleeding soldiers, and inspired the practice of triage. In the US Civil War, "injuries caused by advances in artillery (both cannons and handheld guns) were signified by millions of amputations," and soldiers' experiences provoked the formation of new neurological knowledge about "phantom limbs" (Terry 2009, 207). Later, cancers caused by Agent Orange signified the United States' use of chemical weaponry in Vietnam, and the formation of PTSD, a new category of psychiatric illness in the 1980s, made it a signature wound of that era of warfare (Young 1995). In the post-9/11 wars, "signature wounds" include polytrauma injuries to bones and muscle (e.g. traumatic limb loss) (Messinger 2010a; 2010b), genital injuries (Drury 2011; Janak et al. 2017), moral injury (Shay 2014; Wood 2014), and traumatic brain injury (e.g. Trudeau 2010).

[4] "Signature wound" (e.g. Terry 2009) is used interchangeably with "signature injury." I use the term "injury" because it evokes the kind of physical injury that I want to emphasize, and for consistency with "traumatic brain injury."

Reflecting on what appears to be an increase in public discourse about the "signature injuries" of the post-9/11 wars, Terry observes that soldiers' injured bodies have taken on a new significance:

> The increasingly common usage of these terms ["signature wound" and "signature injury"] suggests an interesting move toward marking wars through a historiography of wounds; that is, as a means through which to construct a history of armed combat that foregrounds the wounding capacities of new weapons systems and the damage they can do. While the terms have been used lately by physicians, psychologists, and journalists reporting on the war, their growing prominence may well have an impact on the subdiscipline of military history that has tended to focus on specific "events" […] of battles or on the biographies of significant military leaders and the tactics they carried out (Terry 2009, 221 n. 2).

As Terry observes, the body is central to the concept of the "signature injury." The "signature" is the literal inscription left on the body by bullets and shrapnel, and bombs and grenades are a kind of calling card left by combatants. The Oxford English Dictionary lists fifteen forms for the word "signature" (Third Edition, September 2011). Most familiar, perhaps, is signature as a distinctive mark. A person's handwritten signature is a mark that authenticates a document. A signature also refers to a distinctive mark on a plant or an animal, such as its markings or color. As an adjective, a signature distinguishes one thing from another, as in a signature dish associated with a distinctive style of cooking.

Less commonly, a signature suggests a path forward. For instance, the signature of written music indicates the key in which a composition should be played. In this case, "signature" is the "sign, or set of signs, indicating the key or meter of a piece of music […]

placed immediately after the clef" (Oxford English Dictionary). For a pharmacist, a signature is "the part of a prescription that gives the wording for the label of a medicine, [specifically], the directions for its use by the patient" (ibid). Thus, a signature is an imprint or a mark. It distinguishes one thing from another. A signature may also define the parameters of something (as a piece of music), or guide how something is interpreted, used, or put into practice (as a medical prescription or a piece of written music).

In this dissertation, I engage the idea of the "signature" in this expanded sense to explore how mild traumatic brain injury organizes clinical encounters, provokes veterans' movement, disciplines clinicians' attention, and highlights some aspects of veterans' lives while it obscures others. When mild traumatic brain injury is problematized as a "signature injury" it points to ways veterans' bodies have been marked by war, but it also guides and defines the VA's institutional efforts to govern veterans.

GOVERNING VETERANS

By observing that "signature injuries" may provoke a change in the historiography of war, Terry (2009) points to a shift from foregrounding *why* soldiers were ordered to do something, to foregrounding *how* wars shape soldiers' bodies. This shift mirrors the analytic move made by post-Foucauldian theorists of governmentality, who move away from analyzing grand narratives of the human subject or human history—modes of analysis that tend toward asking "why?"—and focus instead on events and practices at a smaller scale. As Peter Miller and Nikolas Rose write, understanding how the "activity of governing" happens necessitates a move "from why to how" (Miller and Rose 2008, 6). Put differently, studies in governmentality are

united by their attention to techniques, procedures, and "a focus not upon why certain things happened, but how they happened" (Rose et al. 2006, 101).

Techniques and procedures of governance "conduct individuals throughout their lives by placing them under the authority of a guide responsible for what they do and for what happens to them" (Rose et al. 2006, 83). The responsible authority, however, must be a legitimate authority in a liberal democratic society: governing and governmentality describe how power operates when people are free from coercive state control. The freedom that exists in this context is a "regulated freedom" under which people live as either "autonomous individuals to be assisted in realizing their potential through their own free choice, or potential threats to be analyzed in logics of risk and security" (Miller and Rose 2008, 8). Thus, governmentality is a perspective that allows us to see how power operates without a center, "or rather with multiple centres" (Miller and Rose 2008, 9). As an analytical perspective, governmentality "recognizes that a whole variety of authorities govern in different sites, in relation to different objectives" (Rose et al. 2006, 85) and that government produces a variety of meanings and interventions (Miller and Rose 2008).

Government also produces *problems*. When there are many governing authorities with many agendas, each successive regime of governing raises a set of questions: "Who governs what? According to what logics? With what techniques? Toward what ends?" (Rose et al. 2006, 85). One way the ends of government become visible is as responses to situations that have been rendered problematic. Rose and Miller write:

> […] "problems" are not-pre-given, lying there waiting to be revealed. They have to be constructed and made visible, and this construction of a field of problems is

> a complex and often slow process. Issues and concerns have to be made to appear problematic (Miller and Rose 2008, 14).

In this sense, problems are evidence of the logics, techniques, and ends of government. Larger regimes of governance are evident in the language used to describe problems, the experts who are authorized to frame problems (Brown 1995), the people who are "made up" by the problem (Hacking 2006), and the institutions responsible for documenting and monitoring the problem. In this dissertation, I approach mild traumatic brain injury as a "problem" in this sense of being evidence of the regimes of logics, techniques, and ends of particular modes of governance—specifically, control (Deleuze 1991) and targeting (Chamayou 2014). Rendered as a "signature injury," mild traumatic brain injury becomes the basis for intervention in people's lives. It highlights a concern in society, locates that concern under the purview of medicine, points to a group of people affected (veterans with histories of mild traumatic brain injury), and authorizes an institution (the VA) to manage the problem.

The specific characteristics of mild traumatic brain injury are key to how it is problematized. The injury's "invisibility" in the body and the difficulties of objectively assessing post-acute mild traumatic brain injuries situate it in the realm of "non-knowledge" (Decoteau and Underman 2015), which creates a sense of *medical* urgency. At the same time, the injury's new visibility as a war wound creates a sense of *political* urgency. A third condition is key to how mild TBI is problematized: veterans are at once independent citizens *and* people for whom the state has a clear responsibility (I discuss this in more detail below). Their injuries symbolize the wars and veterans' rehabilitation signifies the state's effectiveness at mitigating the effects of the wars. Together, these three conditions create a space for problematizing combat-related mild traumatic brain injury in such a way that it is possible to govern individual behavior and

"manage 'personal' conduct without violating its formally private status" (Miller and Rose 2008, 12).

THE FANTASY OF WAR WITHOUT AMERICAN CASUALTIES

Stories of veterans being denied their benefits by unsympathetic, excessively skeptical, and incompetent federal bureaucracies are familiar. For example, British nuclear test veterans who were exposed to radiation must craft politicized illness narratives to claim pensions and they create private archives to support their claims (Trundle 2011), while British military personnel affected by Gulf War Syndrome navigate a polarized debate about the causation of their illnesses (Kilshaw 2009). However, this dynamic of government dismissal of veterans' needs is not a defining characteristic of the story of mild traumatic brain injury as a "signature injury" of the post-9/11 wars. Rather, the veterans whose experiences I recount in this dissertation are actively summoned to the VA to have their injuries documented. To understand why this is so, it is necessary to understand that veterans' rehabilitation is a national political project.

Historian Beth Linker traces the origins of our current model of hospital-based rehabilitation medicine to the rehabilitation of injured World War I veterans (2011). She writes, "rehabilitation was born as a Progressive Era ideal, took shape as a military medical specialty, and eventually became a societal norm in the civilian sector" (Linker 2011, 7). The Progressive Era (1890s – 1920s) was characterized by reforms aimed at eliminating the economic and social problems caused by the country's rapid industrialization. Neither the infrastructure nor the ideology for rehabilitating injured soldiers existed at the start of the war: "Before the Great War caring for maimed soldiers was largely a private matter, a community matter, a family matter, handled mostly by sisters, mothers, wives, and private charity groups" (Linker 2011, 5). In the

context of Progressive reform, disabled veterans receiving state pensions became a problem to be fixed. Rather than fund the "private matter" of individuals' ongoing care, the dominant belief turned toward the ideology that state-funded care should make people self-supporting and able (Linker 2011, 37). This ideology aligned the views of orthopedic surgeons, who believed that employment was a necessary part of healing, and thus, "orthopedic surgeons became the technicians who would manage and engineer the soldier's body" (Linker 2011, 57). Linker shows that the military and VA programs developed during this time were founded in "the illusion that the human ravages of war could be erased with a technological fix… healed, and thus forgotten" (Linker 2011, 7). Just as all wars have "signature injuries," all wars are meant to be wars without casualties. The wounding and healing technologies change, but the underlying fantasy stays the same—that medicine can restore the damage. Each generation of veterans partakes of this own fantasy in its own way.

Ethnographies of contemporary military technology and veterans' rehabilitation show that the dream of biomedicine erasing the damage done by war is tied up with larger economic, political, and nationalistic ideas. In the contemporary United States, MacLeish (2013) has shown that even before soldiers are hurt and require rehabilitation, they carry material manifestations of this fantasy on their bodies, in the form of armor. MacLeish writes:

> To the outside observer, weapons and armor signify invulnerability and lethal capacity; their technological magic reassures us that soldiers are shielded from harm as they go about the business of exercising national military might—an exercise that is more politically palatable the less it is thought to endanger soldiers' lives (MacLeish 2013, 54).

Today, the US military's ever-developing array of weapons, armored vehicles, and body armor is exemplified, as Emily Sogn (2015) points out, by the so-called "Iron Man" suit that is in development, a kind of exoskeleton intended to be worn by American soldiers to reinforce their joints, monitor their vital signs, and so on. In an example from contemporary Turkey, the state sponsors an *in vitro* fertilization assisted conception program for paraplegic veterans of the Turkish Army (Açıksöz 2015). Açıksöz shows that the "procreative paraplegic veteran body is an excellent poster child" for technoscientific bodily interventions, and the larger national project of capitalizing on these intersections between bodies and technology (2015, 32). Zoë Wool shows that Walter Reed National Military Medical Center in Washington, DC is a place where "national narratives seem to seep out of every corner of Walter Reed's saturated space" (Wool 2015, 129), and where individual soldiers confront the symbolic connections between their bodies and the nation:

> Walter Reed becomes a place where the moral economy of war can jump scales, from individual bodies to the nation at large, from the meaning and value of wars of nations to the qualities of an individual soldier's body and life (Wool 2015, 83).

These examples show that although rehabilitative projects take different forms at different times, veterans' roles as normative parents, nondisabled workers, and healthy citizens are steeped in bioscientific fantasies promising that what is lost in war can be restored, and in that process, the nation will be strengthened. Put another way, injured veterans are wrapped up in what critical theorist Maurice Stevens calls a "recuperative fantasy"—a fantasy that bodies and minds have an original state to which they can be restored after a trauma (Stevens 2011, 175). Veterans'

rehabilitation is grounded in this recuperative fantasy in that the project of rehabilitation imagines that modern medicine can restore a soldier's body to a pre-war state of independence.

The recuperative fantasy is constituted by two interrelated beliefs: the belief that soldiers can be protected from harm, and failing that, the belief their bodies can be restored with biomedical technology. Thus, the recuperative fantasy as it pertains to individual veterans' bodies is part of a larger fantasy that the United States can wage war without American casualties. This second fantasy comes into stark relief through the contemporary use of armed drones, as philosopher Grégoire Chamayou has shown (2015). The use of armed drones, Chamayou writes, ushers in a new kind of warfare. With armed drones, there is a radical separation between soldiers' bodies and the weapons they use to kill others; they are able to kill without being killed. If the fantasy of rehabilitation promises that the risks of war can be repaired, then this new kind of warfare is a radically new iteration of "war without risk" (Chamayou 2015). Thus, part of mild TBI's significance as a "signature injury" is that it supports the part of the fantasy that relies on the US military's technological, strategic, and economic capacities to protect its personnel—if not from concussion, at least from death.

INSTITUTIONAL PARADOXES

After the military's armor and its methods of technologized destruction fail, and people have been killed and injured, rehabilitation becomes a key site of repairing the undermined fantasy of war without American casualties. Thus, the VA becomes a key institution in this larger project. Rehabilitation is a medical project that relies on biomedicine's promise to restore bodies and minds (cf. Stevens 2011). However, rehabilitation is not exclusively a medical project. Consonant with the scope of its responsibility for upholding this fantasy, the VA is

empowered with an institutional scope that exceeds the scope of a regular hospital: it provides funding for education, home loans, transportation to and from doctors' appointments, and so on. As I will discuss, veterans come the VA with cognitive problems that have nonspecific causes. Their problems are not straightforwardly treated with biomedicine, and so it is fortunate for both veterans and clinicians that the VA is not a hospital in the conventional sense.

Despite its unique characteristics as a hospital, the VA is still characterized by paradoxes that we see in other institutions. In this sense, the VA is a quintessential institution, and its everyday problems, paradoxes, and frustrations are like those anthropologists observe in prisons, psychiatric institutions, hospitals, social service agencies, and government programs.

Some of these paradoxes emerge because institutions have the power to force unwelcome intrusions on people, particularly institutions involved in administering health care, such as prisons (Rhodes 2004; Waldram 2012), psychiatric institutions (Hejtmanek 2015), locked hospital wards (Rhodes 1991), mental health courts (Brodwin 2015), and veteran treatment courts (MacLeish 2015). In such spaces, the people who are managed by the institution occupy multiple and conflicting subject positions. In psychiatric custody, inmates are both patients and prisoners (Hejtmanek 2015; Rhodes 2004; Waldram 2012). In emergency forensic situations, rape victims are patients whose bodies contain evidence that must be collected (Mulla 2014). In emergency psychiatric units, patients must be treated and moved out as quickly as possible (Rhodes 1991). Even people who do not live in institutions but use their services—such as community psychiatry and home care aides—are paradoxically independent and dependent at once (Brodwin 2013; Buch 2013; Myers 2015).

People who work in institutions navigate contradictory obligations organized around the different subject positions occupied by the people in their charge. They experience double binds,

and a sense of futility in their work (Brodwin 2013). Case managers and civil servants do not simply implement the policies that their organizations or the government makes; they are always negotiating the ethical contours of the situations they are faced with (Brodwin 2013; Fassin 2015). Didier Fassin calls this "space to maneuver:"

> Indeed, [the state's] agents are confronted with explicit and implicit expectations formulated in discourses, laws and rules while keeping sizeable space to maneuver in the concrete management of situations and individuals (Fassin 2015, 4).

Though laws and rules abound, institutions seem always to be elusive—somehow elsewhere and impossible to locate, even from inside. In his ethnography of the US Army, for instance, MacLeish writes, "all this institutional apparatus makes one feel both closely monitored and largely invisible" (MacLeish 2013, 29). And although they can be difficult to locate, institutions seem also to be quite distinct from the broader social context in which they operate, so much so that staff are often protective of the bureaucracies in which they work, and seek to defend them from a public they see as threatening (Hoag and Hull 2017, 20). Finally, institutions both reflect and reproduce the confounding aspects of broader social life (Rhodes 2004, xiv). Because the VA reflects the social world in which it operates, the VA is an archetypal institution. The world around the contemporary VA is one in which we see the overlap of intersecting forms of governance—control and targeting.

DISCIPLINE, CONTROL, AND TARGETING

In his 1977-1978 lectures *Security, Territory, Population* (2007) Michel Foucault traced an "epistemic transformation from a disciplinary economy of power towards that of a governmental economy of power" (Roberts and Elbe 2017, 56). Both disciplinary power and governmental power normalize populations, but in a disciplinary regime of power, the norm is

imposed by an institution according to its needs—schools discipline students, factories discipline workers, and militaries discipline soldiers (Foucault 2007, 63). A governmental regime of power, by contrast, devises the norm through observation of the population being governed. For example, Stephen Roberts and Stefan Elbe (2017) describe a procedure used by governments and international health nongovernment organizations to detect disease outbreaks. Contemporary "syndromic surveillance" looks for anomalies in a population's behavior and uses that non-diagnostic data to detect early signals of disease outbreak:

> Digital syndromic surveillance functions through the constant, omnipresent and (near) real-time monitoring, collection and reporting of a range of *non-diagnostic* (and often open-source) data to detect *early* signals of a new infectious disease outbreak. Rather than waiting for the older, and usually lengthier, process of *direct* clinical and laboratory confirmation of a new infectious disease outbreak, syndromic surveillance systems continuously monitor a wide range of more indirect data – such as reports from hospital emergency departments, hospital admissions, sales of medicines from pharmacies, telephone calls to health advice providers, levels of absenteeism at school and/or workplaces, etc. – for early indications that a new outbreak or even a bioterrorist attack may have occurred (Roberts and Elbe 2017, 47-48, italics in original).

The syndromic surveillance systems Roberts and Elbe describe are exemplary of a new regime of governance that does not rely on normalizing bodies (meaning disciplining bodies to replicate a statistical norm). Of the surveillance system, they write:

> Rather than seeking to plot the normal versus the abnormal to determine the norm through interplay of facts, statistics and figures, algorithmically driven syndromic

> surveillance systems constantly survey in order to detect, determine and report upon that which constitutes the *exception* within the governance of infectious diseases" (Roberts and Elbe 2017, 57, italics in original).

Disease surveillance is still a form of governance—it is an intervention organized at the level of a population. Security and targeting do not signal a break from what Foucault described, nor do they replace the logic of discipline. Instead, the two logics are integrated in a new configuration of apparatuses and structures.

In a short essay (1991), Gilles Deleuze describes a regime of power that he calls "control." He argues that we are seeing institutional environments of enclosure (including the hospital) being replaced by less centralized, more dispersed systems of domination. Since Deleuze first described this logic of control, Chamayou has extended Deleuze's extension of Foucault, describing a regime of power that Chamayou calls targeting (2014). Foucault's spatial metaphor for disciplinary logic was the panopticon (1977). By contrast, the spatial metaphor for control is a smooth space, such as shifting desert sands, or cyberspace (Deleuze 1991; Hardt 1995). Michael Hardt, extending Foucault's observation that power fills social space, helpfully combines the two metaphors when he writes: "Social space has not been emptied of the disciplinary institutions; it has been completely filled with the modulations of control" (Hardt 1995, 35). In other words, we find the spaces around Bentham's central tower in the panopticon prison design now filled with shifting sand. Discipline, and the forms of governance (control, security, and targeting) operate together.

I am interested in understanding the VA as an institution in which these forms of power comingle. To demonstrate how these forms of power intersect in an institutional context, I use the theme of *attention*. By attention, I mean the VA's institutional attention, doctors' and

therapists' clinical attention, and veterans' cognitive processes. I interpret attention as a practice that provides a window into how these regimes of power and knowledge shape the experience of the clinicians and veterans who encounter each other at the VA.

Ethnographic context and research methods: The TBI Clinic at the Western VA

In designing this research, I explored several aspects of combat-related mild TBI. I visited three locations of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and the Defense and Veterans Brain Injury Center (DVBIC), which together form the military's nationwide network of research, administration, education, and clinical centers related to the study and treatment of service members and veterans. I observed two joint Department of Defense (DoD) and VA research conferences on veterans' traumatic brain injury and psychological health. I conducted exploratory research at a private medical clinic offering non-invasive, magnetic neuromodulation for people with neurological issues. The various research, commercial, and government activities that I explored are part a multifaceted and multidisciplinary field of those people concerned with how mild traumatic brain injury affects young military veterans. The large number of possible points of entry into diagnostic technologies and treatment options related to combat-related concussion is itself evidence of the place of this "signature injury" in public discourse about the post-9/11 wars.

In the end, I decided to pursue this research inside the VA. The VA is an institution that produces a great deal of its own research, but there are very few ethnographic studies about the VA itself (exceptions include Finley 2011; Hooyer 2015). In total, I conducted eighteen months of fieldwork in the pseudonymous Western VA Medical Center, from November 2012 through

March 2015. This dissertation is based on data collected in over six hundred hours of participant observation in the VA Health Care System, and a combination of formal and informal interviewing with doctors, therapists, social workers, benefits administrators, and veterans.

Within the medical center and its immediate vicinity, I conducted observation and interviews in several distinct areas. I explored Veterans Service Organizations (national organizations like Veterans of Foreign Wars and the Military Order of the Purple Heart) and their relationship to the VA's financial benefit wing, the Veterans Benefits Administration. I explored Vet Centers, the veteran-run counseling and outreach programs established in the 1960s. I observed and interviewed members of a VA research team conducting neurological research on blast injury in a laboratory, with rats. I also conducted observation and interviews in a clinic at the Western VA dedicated to meeting the needs of veterans who had returned from deployments and left the military within the past five years. The clinic was run by a team of psychiatrists, psychologists, primary care doctors, and social workers, and they provided "one-stop" care for young veterans who were new to the Western VA Medical Center.

During this preliminary research, I became interested in spaces where doctors and veterans together were pulled into the paradoxes of a clinical situation organized around an undetectable and incurable injury. How did VA doctors assess veterans' distant head injuries without using any kind of blood test or imaging? If these assessments did not provide any additional treatment options for veterans, what was the information used for? Why was it being collected? What were the consequences of all this data collection and documentation—for clinicians and for veterans? What kinds of interactions between clinicians and veterans did it produce? How was medical and political knowledge intersecting to shape veterans' post-war and post-military experiences?

These are the questions I write about in this dissertation. I studied them at a specialized traumatic brain injury clinic, the Western VA's Polytrauma/Traumatic Brain Injury Clinic (hereafter, "TBI Clinic"). The clinic was one of a nationwide network of twenty-five VA clinics dedicated solely to caring for veterans who sustained traumatic brain injuries. In 1992, the Defense and Veterans Brain Injury Program was developed, and in 2004, Congress mandated the development of rehabilitation and education services for veterans with "multi-trauma injuries" (Public Law 108–422, Section 302). In February 2005, the VA began creating the Polytrauma System of Care (Cifu et al. 2010). The Polytrauma System of Care is part of the "biomedical/military complex, a significant outlay of capital that has been built up around traumatic brain injuries" (Morrison and Casper 2012, nonpaginated).

Over six and half years (April 2007- September 2013), the TBI Clinics (nationwide) evaluated the past injuries of 108,942 veterans, roughly 16,000 veterans per year. Of the 108,942 veterans who were evaluated by the specialists whose work I describe here, sixty-one percent had sustained traumatic brain injuries, most of which (eighty-one percent) were mild traumatic brain injuries (US Department of Veterans Affairs 2015).

The TBI Clinic offered coordinated assessment and care through an interdisciplinary team of clinicians. Because brain injuries (of any severity—mild, moderate, or severe) cannot be cured with biomedicine, they fall under the purview of the medical discipline of rehabilitation, which (broadly) seeks to support someone's optimal physical and social functioning, given an impairment or a condition that will not be cured (e.g. Parkinson's Disease, blindness, the effects of a stroke). While the Western VA had a regular department of Physical Medicine and Rehabilitation in the six-story hospital building that served all of VA's users, the TBI Clinic was

in an outbuilding. With its dedicated entrance, polished wood floors, and spacious waiting room, it felt more like a freestanding clinic than a department of the hospital.

The team was headed by Dr. Elena Beech, a physiatrist (physical rehabilitation doctor) who was in her early fifties.[5] When the clinic was established in 2005, the hospital administration asked her to head it, and she had been the TBI Clinic's director since then. Elena's colleagues described her as compassionate toward veterans, and humble in her capacity as director of the clinic. Elena saw herself as a team leader, rather than a supervisor. In an interview, she told me:

> What I like about being in the position of a team leader and not a supervisor is that nobody reports to me. I can just say, 'Gosh – you guys are all so smart and you know what you do, and you do it all so well.'

My sense of the team's interactions was consistent with Elena's description; they seemed to have equitable and collaborative working relationships, and there was not a perceptible hierarchy among the team members. I never observed any tension between them or frustration with each other.

During my fieldwork, the TBI Clinic was staffed by a rotating team of a total of fifteen clinicians. Three physiatrists and two neuropsychologists supervised medical residents and postdoctoral fellows; together, the doctors assessed veterans' injuries and suggested treatment plans. Treatment was provided by therapists (in speech and language pathology, occupational therapy, and vestibular [balance] therapy), social workers, and a nurse case manager. Each of the team members reported to the head of their respective departments—Social Work, Nursing, Physical Medicine and Rehabilitation, and so on. Like staff in other interdisciplinary hospital

[5] All participants' names have been changed to pseudonyms.

units, these clinicians were organized into "parallel hierarchies" (Rhodes 1991, 20). In the outbuilding where the TBI Clinic was located, they worked somewhat in their own world. Together, the operated like an independent wheel of which each was a spoke, connected to separate administrative divisions of the hospital.

Along with Elena, the two most experienced clinicians were a neuropsychologist, Mara Danzig, and the nurse, Paula da Rosa, who each had thirty years' experience at the VA. Elena, Mara, and Paula had been with the TBI Clinic from the beginning. In an interview, Elena recounted the clinic's beginnings:

> The [nationwide] Polytrauma Program started, I believe, in 2003-2004. After we invaded Iraq they realized that traumatic brain injury was going to be a bigger injury and something that they needed to be aware of. Polytrauma, particularly from blasts, was something that they needed to be able to gear up to treat. So, at the time there were four centers across the country that were called TBI Centers. And they changed them to Polytrauma Centers and geared them up to deal with severe, multiple organ system injuries. But TBI was still going to be the driver for most of this program.

Elena had been working in private practice when this was happening. "What brought me back to the VA," she told me, "was that I liked the idea of working with a team."

CLINICIANS AND VETERANS

Throughout the dissertation, I retain the medicalized term "clinician" to refer to these various health care professionals (doctors, neuropsychologists, therapists, nurses, and social workers) regardless of their specialty. I do this to mark how they—along with the veterans—are

drawn together *by the clinic.* The clinic is the dominant way that the VA Medical Center's physical space, its data production, veterans' movements, and employees' time are organized. As will become clear, however, the "clinic" in the VA does not share all of its boundaries with "biomedicine." One of my central points is that the people who use the VA—veterans—have a relationship with the institution that may not be strictly medical. Therefore, I refer to "veterans" (and not "patients") to mark an institutional relationship that does not depend on treating a medical condition.[6]

I conducted research in the TBI Clinic for eleven months (May 2014 through March 2015). I observed fifty-four veterans' visits in six months (September 2014 – February 2015).[7] I also observed three six-week cycles of the Cognitive Skills for College program that I describe in Chapter Six. I conducted a total of twenty-eight formal, semi-structured, audio-recorded interviews, fourteen with clinicians (in their offices at the VA) and fourteen with veterans (off-site from the VA). Two veterans who participated also gave me written permission—per my research protocol—to study their electronic medical records to better understand their pathways to the TBI Clinic and their interactions with the VA. I also conducted informal unstructured interviews with clinicians and veterans. In the TBI Clinic, I observed the therapists, nurse manager, and social workers during their regular work, and I observed the team's weekly meetings in which they discussed veterans' cases and produced required documentation.

Every six weeks, a new resident physician rotated through the clinic, and their primary responsibility was conducting the lengthy TBI Evaluations that I describe in Chapter Four. While I was observing the TBI Clinic, Elena and her colleagues trained five resident physicians: two

[6] Clinicians generally referred to veterans as "patients" behind closed doors, but as "veterans" when they spoke in public places. Official VA documents generally refer to the VA's users as "Veterans."
[7] For readers familiar with the VA's clinical work, the visits I describe are "2nd Level TBI Evaluations."

women, and three men. I began my days peering over the resident doctors' shoulders as they reviewed the veterans' paperwork and electronic medical record, and I followed residents as they called veterans from the waiting room and led them back into the clinic. Whenever possible, I observed these visits from start to finish, following as the veteran moved through different offices in the clinic. The residents—who were researchers and graduate students themselves—were interested in my work and usually gave me time to ask veterans questions during exams. It sometimes happened that the doctors and I fell into a rhythm, in which I would ask veterans questions that also interested the doctors, such as: "How did you learn about the TBI Clinic?" "What did you expect to happen during your visit here today?" My observations also included Elena's supervision of the residents, during which the two doctors discussed the veterans' histories and treatment plans.

In 2014, VA Medical Centers across the country provided care for 684,133 veterans of the wars in Afghanistan and Iraq (Taylor 2015, 10). Among those, seven percent (45,845) had a TBI diagnosis (ibid), and among those, VA researchers find that "mental health, particularly PTSD, and pain-related co-morbidity is the norm" (Taylor 2015, 14).

The veterans whom I interviewed and whose clinic visits I observed ranged in age from 25 years old to 45 years old, which is also consistent with the demographics of the group of OEF/OIF veterans, among whom the average age was 36 in 2014 (Taylor 2015, 20). All of veterans who participated in my research entered the military in the enlisted ranks. In their respective military branches, these veterans were truck drivers, air traffic controllers, infantry assaultmen, combat engineers, military police, medics, security forces specialists, and snipers. Only one veteran whose evaluation I observed had never deployed overseas.

In my time at the clinic, I met only two women veterans. This was consistent with the patient population of the TBI Clinic. In 2014, a nationwide total of 683,133 post-9/11 veterans received care from the VA. Thirteen percent of those veterans were women, and only six percent of women were diagnosed as having had a TBI (Taylor 2015).

Perhaps most importantly for my analysis, most veterans had been injured during deployments between 2003 and 2008, though a few had been injured as recently as 2012. That is, their concussions occurred at least two years before they were in Western's TBI Clinic in 2014-2015, and in some cases, up to eight or nine years before they met VA doctors. Determining whether a veteran sustained a mild TBI required a doctor to characterize an event that occurred years ago, whose acute effects the doctor did not witness, and of which there was no detectable trace in the body.

I did not systematically record the branch of service, age, race, or ethnicity of the 54 veterans whose clinic visits I observed. Among the population of OEF/OIF veterans using the VA, 67 percent identified as white, 17 percent identified as black, and 2 percent identified as Asian. Most OEF/OIF veterans (89 percent) identify as non-Hispanic. OEF/OIF veterans identifying as multiracial make up 2 percent of the population, and veterans identifying as Native American/Native Alaskan and Native Hawaiian/Pacific Islander each make up 1 percent of the population. Race and ethnic identity is unknown for 10 percent of the group (Taylor 2015, 20).

It should also be noted that the TBI Clinic is not limited to evaluating combat veterans, nor must their injuries necessarily be combat-related to receive this kind of attention. However, most of the veterans evaluated in the TBI Clinic were deployed to Afghanistan or Iraq because most referrals to the clinic came from the TBI Screening that was designed to be asked to OEF/OIF veterans (Chapter Three). In some cases, their most serious head injuries were *not* from

those deployments. I heard about several football-related concussions, motorcycle- and car-accident-related concussions, and the occasional workplace accident (falls from forklifts, ladders, and bunk beds). In general, the distinction between "military service" and "combat" is not relevant for access to VA services. Veterans who participated in the military during peacetime are equally entitled to VA services and disability compensation. The monetary disability benefits that some veterans receive, for instance, are awarded for *service-related* injuries, which includes repetitive strain injuries, conditions related to training (e.g. hearing loss), common workplace injuries (e.g. injuries from forklifts and machinery), and even chronic conditions (like diabetes) whose onset occurred while a person was in the military.[8] This is another way that we can see the broad scope of the contemporary VA's responsibility for veterans.

CHAPTERS OF THE DISSERTATION

The dissertation has six chapters. The first two chapters explore veterans' relationship to the VA, and the "ends" to which the VA is involved in governing (cf. Rose et al. 2006). Chapters Three and Four concern VA logics and techniques of movement and tracking veterans, and how they are related to producing knowledge about the "signature injury." The final two chapters address the therapeutic interventions that are practiced in the TBI Clinic, exploring the specific actions doctors take in treating veterans with histories of mild TBI.

[8] The most well-known form of disability compensation available to veterans is the percentage-based rating system, known as service-connected disability rating or "service connection." All forms of veterans' compensation – including disability compensation – are managed the Veterans Benefits Administration (VBA), a division of the VA that is separate from the Veterans Health Administration (VHA), which manages the medical centers. VA clinicians who provide medical care do not evaluate a veteran's disability. Among OEF/OIF veterans who received VA care in 2014, about 70 percent had some level of service connected disability (Taylor 2015, 11). Only 28 percent of veterans *with a TBI diagnosis* in 2014 had a service connection rating *for TBI* (ibid).

In Chapter One, I consider uncertainty in medicine and the institutionalization of the federal government's responsibility to rehabilitate disabled veterans. I draw on anthropological and sociological literature about doubt in medicine to show that mild traumatic brain injury is characterized by uncertainty (as opposed to risk). Whereas risk describes a situation in which the likelihood of probable outcomes is assumed to be *known*, uncertainty assumes that probability of outcomes is *not* known. There is no consensus among doctors about the causal relationship between events and symptoms, and therefore the lasting effects of veterans' histories of mild TBI are uncertain. In this chapter, I also draw on historical literature about the VA's past to show two things: first, the nature of the federal government's responsibility for disabled veterans, and second, that the VA has a unique informational infrastructure that it uses to target subpopulations of veterans—in this case, OEF/OIF veterans with histories of mild TBI. Additionally, Chapter One shows how the VA became a teaching hospital, and it introduces the clinicians who participated in this research.

Chapter Two introduces the veterans who participated in this research. I discuss the problems they experienced after leaving the military, some of which they attribute to the "transition" from the military to civilian life. My discussion of veterans' lives in this register is in conversation with ethnographic moves to "demedicalize" health and illness, which include ethnographic accounts that decenter trauma as a central explanatory concept in service members' and veterans' lives. I show how the VA's responsibility for managing problems created by the military can seem, from veterans' perspectives, like a bait and switch. In making this argument, I focus specifically on veterans' memories of leaving the military. Their memories highlight themes of idealized teamwork, reciprocity, and transparency in a contractual relationship with

their respective branches of the military. Veterans experience their relationship with the military as a participatory one, whereas by contrast, the VA offers no such participation for veterans.

In 2007, the VA introduced a new protocol for screening OEF/OIF veterans for histories of head trauma. This screening procedure is the subject of Chapter Three. I argue that the screening procedure problematizes mild TBI as something to be detected in a population, and I describe how the process works like a "net" made up of the VA's electronic medical record system and the TBI Clinic staff's "clinical relentlessness." Drawing on post-Foucauldian theories of control and targeting, I analyze the screening procedure as an institutional technique of moving veterans to and within the VA. My analysis advances ethnographic accounts of how institutions move people and things and with what effects. My contribution to this literature is to show that in the VA—somewhat paradoxically—veterans' movements signify a stable, predictable relationship with the institution.

Chapter Four is an ethnographic account of how doctors diagnose old injuries whose effects they cannot detect in the body using traditional clinical methods. My analysis shows that doctors direct their clinical gaze at objects and past events, rather than at veterans' bodies. In showing how the gaze is redirected in this clinical context, I extend Terry's (2009) observation that we are witnessing a shift in military historiography from large-scale strategic events (battles, military strategic decisions) to the effects of war that register at the level of the body. In my analysis of doctors' use of "good stories" as diagnostic tools, I show that in fact, "signature injuries" do maintain a focus on events—the events that affect veterans' bodies.

In Chapter Five, I turn to clinicians' anxieties about the tracking, assessing, and documenting described in the preceding chapters. VA clinicians are cautious about the hazards of discovery (to using Hacking's [2006] terminology), and they worry that problematizing mild TBI

as a "signature injury" makes up a "kind" of person who is permanently impaired by the effects of mild TBI. To prevent this from happening, clinicians engage in what I call "expanding the etiology" of veterans' symptoms. Their therapeutic intervention foregrounds their uncertainty. My analysis (and, to some extent, the clinicians' therapeutic intervention, too) draws on a foundational insight in the study of disability—that disability is a social dynamic. I put insights from Disability Studies in conversation with anthropologists' observations about productive uncertainty in medicine to show why and how VA doctors actively foster uncertainty in the TBI Clinic.

In Chapter Six, I provide another example of clinical encounters in the TBI Clinic. I describe a VA program designed to meet the needs of veterans who experience cognitive problems while attending colleges and trade schools. My analysis centers on embodied minds. In the context of the present "neurological turn," veterans act as "somatic individuals"—in Nikolas Rose's (2003) terms, they locate their cognitive problems in their bodies, and specifically, in their brains. However, clinicians, promote a different perspective, emphasizing instead the brain's plasticity—a relatively recent development in neuroscientific knowledge that shows how the brain changes in response to its environment. Clinicians propose that instead of seeing their brains as damaged organs, veterans learn to understand their embodied minds as a source of *continuity* in an otherwise shifting social life. By encouraging veterans to "thinking about thinking," clinicians posit that veterans experience a "misfit" between their brains and their new social environment. I argue that veterans' experiences and VA clinicians' therapeutic efforts are fertile ground for understanding how institutions produce "minded bodies" (Pitts-Taylor 2016).

CHAPTER 1. THE FANTASY OF REHABILITATION

> I predict—and this is me, and my predictions aren't worth a damn—but I predict that traumatic brain injury is going to be the Agent Orange of this conflict.
>
> Retired Army Gen. Peter Chiarelli, *Politico*, September 20, 2012

> If the conduct of individuals or collectivities appeared to require conducting, this was because something in it appeared problematic to someone.
>
> Miller and Rose 2008, 14

In a 2011 editorial, a retired Army Brigadier General wrote: "Wars are followed by public health epidemics. What a shame that we might neglect another generation of heroes. If we continue to do this, can we ever ask young people to fight for us again?" ("Agent Orange *déjà vu*," June 8, 2011, *The Hill*). In 2012, another retired Army General, Peter Chiarelli, repeated the warning, suggesting to a reporter at *Politico* that mild TBI would become the Agent Orange of the post-9/11 wars. These powerful advocates for military mental health were not suggesting that mild TBI might be found to cause cancer and genetic mutations like the herbicide Agent Orange,

used during the country's war in Vietnam. Rather, the comparison they made was to the invisible effects of a substance thought to be harmless, effects that went undetected and then ignored, until it was finally accepted that many members of a generation of military veterans had been harmed in the same way. The generals' warnings seem particularly ominous because what prompts the sense that we have experienced this before is *uncertainty*. Perhaps combat-related mild TBI causes lasting health consequences for a whole generation of veterans, but it may be years before we know.

Mild traumatic brain injury brings to the fore the uncertainties that characterize the practice of medicine. It is unclear whether the injury has permanent effects on the brain, and scientists' efforts to study that question are hindered by a lack of known biomarkers to anchor objective testing. There is no way to repair damaged brain tissue, and doctors' therapeutic options are limited to treating veterans' symptoms. Doctors foresee a future in which more knowledge and treatment options exist, but they are confronted with a new generation of combat veterans *now*.

This chapter explores the intersection of uncertainty in medicine with the political mandates of institutions. First, I draw on anthropological and sociological literature about doubt in medicine to show that uncertainty about combat-related mild TBI is best understood as an instance of "non-knowledge" (Decoteau and Underman 2015). Then, I draw on historians' analysis of pivotal reforms in the VA's one-hundred-year history to establish two essential points: first, the federal government is responsible for rehabilitating disabled veterans, and second, the modern VA is an institution that produces an enormous amount of information and uses it to target subpopulations of veterans. The former is the ideological foundation of the TBI

Clinic at Western, and the latter is the practical and technological foundation of the doctors' work.

This dissertation integrates clinicians' and veterans' perspectives in an ethnography of an institution that highlights the particular paradoxes and intersecting forms of attention shaping the construction of mild TBI. Here, however, I begin with a focus on VA clinicians, alone. In addition to exploring the stakes of non-knowledge around mild TBI, this chapter introduces the ethnographic context. The VA's history explains why the VA looks as it does today, who is responsible for the care of veterans, and why the VA feels like an academic space focused on biomedical research. One of purposes of this chapter is to explain who the clinicians are, how they come to be working at the VA, and what that work entails. To that end, I pair my own ethnographic and interview data with historical and archival material to convey something of the experience of working in the contemporary VA, which for many clinicians is accompanied by the feeling that at any moment, their work may become the object of a very public investigation.

UNCERTAINTY ABOUT THE EFFECTS OF MILD TBI

At the time of my fieldwork there was no scientific consensus about the causal relationship between veterans' old injuries and their present symptoms. Veterans who visited Western's TBI Clinic told doctors that they had trouble remembering conversations they had, or places they had been. They had intractable headaches. They were irritable with their kids. They forgot to pick up the dry cleaning. They could not remember what they were supposed to do during the day without making lists. They went to the grocery store, only to forget to look at the grocery list, and come home without whatever they went for. They said that they "spaced out" while driving on the highway.

Current medical research suggests that 50 percent to 80 percent of people who sustain concussions might experience these kinds of cognitive (memory and attention deficits), emotional/behavioral (irritability, anxiety, depression), and physical (fatigue, headache, dizziness) symptoms. When these symptoms occur within days—or months, at the longest—of a mild TBI, they are considered post-concussive symptoms (Sayer 2012). However, most of the veterans whose medical care I observed in 2014 and 2015 were injured during deployments between 2003 and 2008. Those who had been injured most recently were injured in 2012. That is, their concussions occurred *at least* two years before they were in Western's TBI Clinic and their symptoms fell well outside of that days-to-months window for post-concussive symptoms.

Since connecting veterans' cognitive, emotional, and physical symptoms to years-old concussions was not consistent with the current evidence in medicine, clinicians noted that that the irritability, attention deficits, fatigue, and headaches about which veterans complained were things all people experience regularly. These symptoms could be associated with many different illnesses and mental health concerns. For instance, one doctor explained that the symptoms themselves were not specific to any single problem:

> The state of the science is not there to say that I can tell you one-hundred percent that [one] particular symptom is coming from *X* and that other symptom is coming from *Y*. We don't have that.

In other words, not only might veterans' symptoms be caused by anything, but the most reliable medical evidence at the time suggested that they were *not* caused by years-old head injuries.

To complicate matters, there are currently major limitations in visualizing the effects of concussions in the brain. A mild TBI is a brain injury in which structural imaging (magnetic resonance imaging or computed tomography scanning) is normal (O'Neil et al. 2013). In other

words, by definition, patients' brains appear normal on standard medical imaging. Mild TBI is also invisible in a more symbolic sense. In 2008, a widely-circulated study published by the RAND Corporation named mild TBI one of the "invisible wounds of war." The authors were interested in drawing attention to post-traumatic stress disorder, major depression, and TBI because "unlike the physical wounds of war, these conditions are often invisible to the eye, remaining invisible to other servicemembers, family members, and society in general" (Tanielian and Jaycox 2008, iii).

Although cellular-level injuries are invisible, concussions cause metabolic changes in the brain as well as cellular-level changes known as axonal stretching (McCrea 2008); researchers spend time and money looking for ways to detect and remedy those changes in living patients. The ability to test for concussions immediately after injury matters because the brain may be more vulnerable for days after the trauma; for athletes and service members alike, such an objective test would mean that they could be held from play and duty until the additional vulnerability had passed. However, there are limitations in both testing and treatment, in humans, for mild traumatic brain injuries. Treatments developed in animal models still do not translate to treatment in humans, but researchers consider recent studies that use structural MRI, functional MRI, diffusion tensor imaging (MacDonald et al. 2011), and studies of cerebrospinal fluid to be indications that it may be possible to detect physiological damage from brain injuries (see, for example, DePalma and Hoffman 2018).

Medical literature about post-concussive symptoms is based primarily on research about concussions that occur in everyday life – falls, sports injuries, and so on. This fact opens another space of uncertainty because it is plausible that *blast-related* concussions (like those sustained by many veterans) would be different than injuries sustained by, for instance, high school athletes.

Blast-related concussions occur under traumatic circumstances where soldiers may fear for their lives or witness others' deaths, and in soldiers, PTSD is strongly associated with mild TBI (Hoge et al. 2008). PTSD and mild TBI occur together so often that it recently took a VA research group three years to recruit twenty-four veterans who had a recorded history of TBI, but no diagnosis of PTSD—and this was at one of the largest VA hospitals in the country (Mendez et al. 2013). Beyond the traumatic context of the injury, combat-related concussions are unique in that they involve a "blast"—the pressure wave generated by an explosion—and medical research suggests that blast waves alone can injure the brain on a cellular level (MacDonald et al. 2011).

The VA clinicians who participated in my research maintained a cautious skepticism about these debates – they avoided being swayed by unproven theories that IED blasts were uniquely damaging, but they also readily acknowledged the limitations of their knowledge. Dr. Mara Danzig, the most senior and most experienced VA neuropsychologist I interviewed, spoke poignantly about the difficulties of working with this uncertainty:

> I think one issue for the veterans is that they're worried about their long-term health. Are they going to be like those football players who had multiple concussions? What's going to happen to them? And I think we don't know the answer to that question. One or two concussions, probably no risk at all. But some of the patients have a lot more than that.

The football players to whom Mara referred are professional athletes whose repeated head trauma caused them to develop a progressive neurodegenerative disease called chronic traumatic encephalopathy (CTE) (Mez et al. 2017). CTE can only be diagnosed by autopsy, so much of what is known comes from researchers' evaluation of brains that were donated for postmortem study. During my fieldwork at the VA, the National Football League (NFL) was involved in a

class-action lawsuit, which, when it was settled in 2015, allowed former players and their families to claim up to $5 million in compensation for diagnoses of amyotrophic lateral sclerosis (ALS), Parkinson's, Alzheimer's or dementia to make claims to monetary awards from the NFL (Almasay and Martin 2015; Maese 2017).

Overall, mild TBI presents a situation characterized by doubt and uncertainty. Though there is evidence that concussive injuries heal, there is no evidence that multiple, blast-related concussions are *not* harmful in the long-term. Veterans' injuries seem obviously different from those of youth athletes, just as they seem different from those of professional football players. Yet, the post-mortem research on professional athletes' brains contributes to the specter of future effects that Mara speaks to— "What's going to happen to them?" Although this question about concussions long-term effects is relevant to any person who sustains a brain injury, when it a question asked about veterans, it becomes a political and moral question. What appears now as a limitation in imaging technology, or a lag between lab research and its clinical applications, has the potential to turn into a scandal about veterans' health care sometime in the future.

PERSPECTIVES ON UNCERTAINTY IN MEDICINE

Because there is a debate about what causes young veterans' post-concussive-like symptoms to persist years after their injuries, mild TBI brings the uncertainties of medicine to the foreground in an explicit way. As medical sociologist Renée C. Fox observes, "uncertainty is inherent in medicine. Scientific, technological, and clinical advances change the content of medical uncertainty and alter its contours, but they do not drive it away" (Fox 2000, 409; see also Fox 1980). Existential uncertainty characterizes patients' experiences of illness, doctors'

work of diagnosis and treatment is characterized by clinical uncertainty, and together these forms of uncertainty shape the medical encounter (Adamson 1997).

For patients, seeking certainty in medical diagnosis can generate anxiety, as Sarah Nettleton shows among people living with medically unexplained syndromes and unexplained pain (Nettleton 2006). On the other hand, patients may embrace the unknown outcomes of confirmed diagnoses. Ian Whitmarsh and co-authors describe families' reactions to "genetic uncertainty," when genetic diagnosis confirms a medical condition with symptoms that may never be exhibited. In this case, families not only accept the uncertainty, but question the authority of genetic diagnoses (Whitmarsh et al. 2007).

Doctors' relationship to their profession necessitates managing uncertainty about diagnosis and treatment outcomes. Seth Holmes and Maya Ponte (2011) show that one of the ways doctors manage uncertainty in everyday medical practice is by learning the practice of "en-case-ing" their patients, categorizing their "uncertain, chaotic illness experience" into recognizable "textbook" clinical cases, using a standard patient presentation format. Medical residents learn to "limit and background the portions of the patient's illness narrative—particularly social and economic circumstances—which would generate uncertainty as to the potential causes and treatment of the patient's problem within a medical framework" (Holmes and Ponte 2011, 172).

Following the diagnostic process of "en-case-ing" a patient, doctors still face uncertainty in treatment. For instance, as Carolyn Rouse observes, doctors experience "therapeutic uncertainty" when their patients' health does not improve with treatment, or when the benefits of treatment are unclear. When such "uncertainty" characterizes the medical treatment of black American patients, Rouse argues, it re-entrenches racist assumptions: "despite all the medical

uncertainty, noncompliance continues to be used as an explanation for significant disparities in rates of morbidity and mortality" (Rouse 2010, 194). When black American patients are described by doctors as "noncompliant," the move protects the authority of medicine, perpetuates stereotypes about irrational patients and racist doctors, and makes no progress toward eliminating the health disparities that produce shorter life expectancies for black Americans than white Americans. In a different example of how the authority of medicine is maintained despite doctors' uncertainty, Annette Leibing (2009) shows that Brazilian doctors navigate the unknown efficacy of Alzheimer medications by expanding the category of "efficacy" beyond cognitive symptoms; such drugs can be said to be "effective" if "efficacy" indicates improvements in functionality, quality of life, and activities of daily living.

Beyond doctor-patient clinical encounters, the dynamics of uncertainty in medicine operate at the institutional level, where hospitals, policy, and the state become involved. At this level, the stakes of causality are state recognition and compensation, when disease and disability become the basis of biological citizenship, structuring and regulating individuals' relationships to the state (Petryna 2002). Veterans' experiences are a prime example of the stakes of uncertainty in illness causality. For example, Catherine Trundle's research on British nuclear test veterans seeking state compensation for their war-related illnesses shows that veterans bear the burden of producing evidence of causality from state archives (Trundle 2011). More broadly still, when the state sanctions childhood vaccines, doubts about medicine's authority become challenges to the state's authority, as has been the case with uncertainty about the cause of autism (Bazylevych 2011). Sharan Kaufman calls autism "an exemplar of the condition of uncertainty today" (2010). Kaufman writes, "because it is a mutable object of knowledge, with unknown specific etiology, and because the well-being of children and families is at stake, autism has become a pivotal

figure in conversations about the truth claims of biomedical science and about what constitutes evidence and credible knowledge" (Kaufman 2010, 12). In their analysis of the 2007-2008 hearings in the United States to assess the evidence for claims that vaccines were linked to autism, sociologists Claire Decoteau and Kelly Underman show that "non-knowledge" is a major feature of autism science. While the scientists involved the proceedings argued that there was sufficient evidence to show that vaccines are not a causal factor in autism and that the pertinent area of non-knowledge is genetics, the parents' case was based on the claim that that since no part of autism science is complete, non-knowledge exits everywhere, and therefore future scientific research should not be contained to the study of genetics. As Decoteau and Underman summarize, "risk assumes that the probabilities are known whereas uncertainty assumes they are not," and that the different sides of the debate about autism causality require that we see how "the distinction between risk and uncertainty indicates different perspectives on the 'doneness' of the science of autism" (Decoteau and Underman 2015, 480).

When TBI Clinic doctors at the Western VA expressed concerns about veterans' long-term health and the consequences of brain injuries ("Are they going to be like those football players who had multiple concussions? What's going to happen to them?") they are engaged in a conversation about uncertainty (as opposed to risk). In the doctors' view, the science of combat-related mild TBI is 'undone' (cf. Decoteau and Underman 2015). They believed that with time, biomedical knowledge of the long-term effects of concussions will improve. One of the ironies of the present uncertainty about how concussions affect people in the long-term is that doctors feel certain they will know more in the future. For instance, an experienced neuropsychologist explained in an interview that she was hesitant to act as if concussions have no long-term effects:

> I think that we have to really reserve our judgement about what's going on, because I have this feeling like in ten years' time, we're going to know a lot more and then we're going to realize we told everybody the wrong thing! [She laughed.]

Elena, the director of the clinic, anticipated a future in which doctors would have more treatment options:

> I think at some point in time, we will have more information and we will be able to target symptoms based on why [the symptoms are] there.

Elena's comments point to a generalized sense that VA doctors and veterans were interacting in a kind of *meanwhile*—until imaging technologists develop new ways to visualize injured brains in more precise ways, until laboratory scientists isolate biomarkers for concussions, until we know more. During this meanwhile, debates about why veterans' post-concussive-like symptoms persist produced an uncertainty that hung over the TBI Clinic and shaped its everyday operations. To fully appreciate how this particular uncertainty shaped the TBI Clinic, it is necessary to understand how and why the VA became responsible for veterans' health and rehabilitation. In the next sections, I point to moments in the VA's history when concerns about a whole population of veterans were institutionalized, first as a federal imperative to rehabilitate disabled veterans, and second as a modern adaptation to running the VA as an accountable care organization.

THE VA'S BEGINNINGS: REHABILITATING VETERANS (1917 – 1930)

The conceptual distinction between war veterans' earned benefits, on the one hand, and unearned welfare for the poor, sick, and disabled, on the other, is deeply entrenched in western

societies. As historian David Gerber's (2000) volume on the history of disabled veterans points out, this moral-conceptual differentiation of veterans from the "undeserving poor" dates to the seventeenth century, when two separate tracks of government assistance were present in England, during the French Revolution, and later, during the American Civil War (Gerber 2000, 11-16). Although the ideological commitment to the US government supporting war veterans can be traced to the American Civil War, dedicated and exclusive veterans' *hospitals* in the United States are a much newer formation (see also Linker 2011). The contemporary VA's specific and direct institutional lineage encompasses a major policy shift that moved disabled veterans' rehabilitation from the private to the federal domain.

When World War I began in 1914, the total population of US veterans was small, but the cost of their pensions, administered by the federal Pension Bureau, exceeded the cost of the Civil War itself (Linker 2011, 12). Veterans was paid cash by the government, and their care was a private or community endeavor. In 1917, the United States declared war on Germany and began drafting men to serve in the military. Since paying pensions like those paid to pre-World War I veterans would become too expensive when paid to new generation of four or five million young veterans, it became necessary to revise veterans' benefits (Linker 2011, Chapter 1).

To preempt this impending expansion of "the problem of the pensioner" (Linker 2011, 28), President Woodrow Wilson solicited proposals for a new way of organizing veterans' benefits, which yielded a plan for the government to rehabilitate would-be pensioners so that they could re-establish independence. As historian Beth Linker shows, rehabilitation policies were exemplary of Progressive-era ideological commitments to "the illusion that the human ravages of war could be erased with a technological fix… healed, and thus forgotten" (Linker 2011, 7). In 1917, Progressive-era reformers' vision of wounded combat veterans as laborers to

be restored was codified into law, when Congress passed the War Risk Insurance Act, so named because it extended existing insurance for merchant *ships* to veterans themselves—the "human material" of war (Linker 2011, 29). The 1917 policy change required the federal government to provide medical care and rehabilitation services for the transformation of disabled veterans into self-sufficient, working citizens (Linker 2011, 32). The significance of this policy change was to shift veterans' rehabilitation from being a private matter to a public matter. Veterans' rehabilitation—once veterans' own responsibility—became the state's responsibility. The 1917 policy change was revolutionary because it committed the federal government to provide medicine for veterans.

However, in 1917, there was no VA to provide this now-mandatory medical care for disabled veterans. The new policy was administered out of the Treasury, and the medical and rehabilitation benefits it guaranteed to disabled veterans were "patched together" through contractual arrangements between the Treasury's Bureau of War Risk Insurance, the Army, and the US Public Health Service (Stevens 2012, 49). In 1921, more than 98 percent of federal funds spent on veterans' hospitalization were spent on contracts with the Public Health Service and the War Department (Stevens 2012, 44). In other words, the Treasury was outsourcing veterans' health care to existing hospitals run by other federal services. About 20,000 veterans were being treated as inpatients in this "patched together" collection of hospitals, and it was anticipated that another 30,000 beds would become necessary within the year for treating tuberculosis, mental illness, and general medical and surgical conditions (Stevens 2012, 49). Even before the war ended, it was clear that the Public Health Service's hospitals were too small to accommodate the returning veterans. An organized hospital system of some kind was needed (Stevens 2012, 44-45).

In March 1921, President Wilson signed a law that appropriated $18.6 million dollars (almost $248 million 2017 dollars) for the creation of dedicated veterans' hospitals. The veterans' hospitals were to be designed by an appointed committee of unpaid "consultants in hospitalization" chaired by Dr. William Charles White, a tuberculosis specialist (Stevens 2012, 50).[9] The consultants held hearings with public and private groups, visited hospitals, and made detailed maps of hospital locations throughout the country. The American Legion, still a powerful veterans' lobby today, was among the groups that lobbied for dedicated veterans' hospitals, reflecting a modern manifestation of the longstanding moral and political differentiation of veterans from the "undeserving poor." The White Committee agreed, and recommended building a system of permanent federal veterans' hospitals. The White Committee also proposed that the newly consolidated hospital system become a new branch of government headed by a cabinet member.

When President Warren G. Harding took office in March 1921, he took the White Committee's recommendation and began consolidating veterans' services into a single bureau. This process began with the formation of another committee, headed by Charles G. Dawes, a banker who had been an Army General in charge of the Army's supply service in Europe. Based on the White Committee's recommendations, the Dawes Committee modeled a new Bureau that would handle the compensation previously paid through the Bureau of War Risk Insurance, the Public Health Service hospital beds and programs used by veterans, and all the veterans' vocational rehabilitation services that were then housed in the Federal Bureau of Vocational Education. Thus, in August 1921, one of the institutional predecessors to today's VA was established: the Veterans Bureau (Stevens 2012, 50-53).

[9] Formally, the committee was titled Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384 (Stevens 2012).

With the formation of the Veterans Bureau in 1921, veterans' services were consolidated into a single, independent, federal organization. The significant change marked by the Veterans Bureau was not the creation of programs for veterans—all the benefits and entitlements afforded to veterans (federal funding for health care, rehabilitation, pensions, etc.) existed before the Veterans Bureau was formed. Rather, the significance of the Veterans Bureau was the consolidation of these programs into a single federally administered program. The Veterans Bureau only existed for about eight years, and it was plagued by scandal. [10] After the Bureau's first director was indicted for fraud, he was replaced by a former Army commander and a politician with no background in medicine, Brig. Gen. Frank T. Hines. Hines reconfigured the Veterans Bureau into a centralized, hierarchical organization, and that blueprint was reproduced as the Bureau grew and changed. When President Hoover, in July 1930, initiated another phase of centralization by merging the Bureau of Pensions, the National Home for Disabled Volunteer Soldiers, and the Veterans Bureau, Hines' influence carried over: when the Veterans Administration was created in 1930, it was highly centralized in Washington, DC. The problems with such a centralized Veterans Administration emerged around the practice of modern medicine, and they became apparent when a new generation of combat veterans returned to the United States after World War II.

[10] Moving all veterans' services into the Veterans Bureau was supposed to insulate hospital care from the politically-motivated favoritism that had plagued the previous, contract-based model. However, consolidating veterans' care and rehabilitation necessitated building and renovating hospitals, work that was attached to lucrative construction contracts. In the final weeks before the new Veterans Bureau would officially absorb the last of the disparate veterans' programs (the Bureau of War Risk Insurance), President Harding appointed his friend Charles R. Forbes to a position that would make Forbes the director of the new Veterans Bureau (Stevens 2012, 52). Forbes promptly became the center of a federal fraud scandal which involved his sale of the Veterans Bureau's building supplies to a private firm in Boston for twenty cents on the dollar. Upon the discovery of this fraud in 1923, a Senate committee was convened to investigate the Veterans Bureau and suggest reforms. Forbes resigned, and he and one of the contractors were indicted and ultimately, convicted. Forbes was fined and sentenced to imprisonment in Leavenworth federal penitentiary.

ACADEMIC MEDICINE (1945 AND 1946)

The post-World War I-era Veterans Bureau was plagued by fraud; its World War II-era replacement, the Veterans Administration, was plagued by scandals surrounding medicine. By the mid-1940s, VA hospitals were criticized for providing medical care that did not meet contemporary standards of biomedical practice.

In 1945, a series of articles published in *Cosmopolitan* reportedly "caused a national uproar" (Klein 1981, 44). The journalist, Albert Q. Maisel, had done previous reporting based on six months in the field with the Navy's Medical Department, and published a book titled *The Wounded Get Back* (1945a). Upon completion of that project, Maisel started reporting on the Veterans Administration hospitals, where some of the soldiers he saw treated aboard Navy medical ships would have ended up. In an article titled, "The Veteran Betrayed: How Long Will the Veterans' Administration Continue to Give Third-rate Medical Care to First-rate Men?" Maisel reported that the VA hospitals were shockingly different from what he saw aboard Navy hospital ships:

> No soldiers on earth receive better medical care than our own. […] But I have been shocked and shamed to discover that these same service men, after they have received a veteran's honorable discharge, are suffering needlessly and, all too often, dying needlessly in our Veterans' Hospitals. […] We have never stinted the Veterans' Administration. We have given it over a quarter of a billion dollars for nearly a hundred great hospitals. […] But the conditions in these beautiful buildings are far worse than cold statistics can indicate (Maisel 1945b, 45).

Maisel's 1945 series is particularly interesting because he focused on the provision of basic health care. Although the journalist did research in all kinds of VA hospitals, he ultimately wrote

about tuberculosis hospitals; as such, his reporting avoided the well-worn path of condemning the moral disgrace of abandoning war-wounded soldiers. Maisel compared veterans' hospitals to state and county hospitals—hospitals that were equally "tied down by government restrictions and labor shortages"—but where he found lower death rates, higher treatment and cure rates, at lower costs per day per patient than in VA hospitals (Maisel 1945b, 45). Maisel's investigation caused him to conclude that substandard care for veterans could only be explained by "incompetence and complacency" (Maisel 1945b, 46):

> This is no war-created situation. The Veterans' Administration has been "achieving" this desperately poor record for two decades (Maisel 1945b, 47).

Maisel's reporting pointed to the consequences of the centralization of the VA's administration of twenty years before. For this "desperately poor record" in health care provision, Maisel blamed the VA's overwhelming bureaucracy, which was managed by VA's Central Office in Washington, DC, and he argued that the cause of substandard medical care was the very centralization that had been designed to prevent the fraud that occurred in the Veterans Bureau during World War I.

Another journalist, Albert Deutsch, arrived at the same conclusion based on his own three-month study of the Veterans Administration's medical activities in 1945. Writing in the New York *PM Daily*, Deutsch described the VA's Central Office as a:

> … bewildering labyrinth of corridors […] lined with big file cabinets that have spilled over from the crowded offices. Everywhere you bump into boys and girls trucking stacks of files from one office to another. Stenographers, hundreds of them, intently type away at forms in duplicate, triplicate, quadricate (Deutsch 1945a).

Both journalists perceived a problem with the VA's centralization, which was apparently an overcorrection after the problems with the fraudulent Veterans Bureau. Deutsch predicted, "If corrective action doesn't come quickly and vigorously, a scandal of major magnitude may ensue" (Deutsch 1945a). This time, however, the scandal would not break over government fraud as it had fifteen years before. Instead, Deutsch's investigation suggested that the new scandal would erupt over substandard medical care that was due to incompetent executives, a massive bureaucracy that was more concerned with preventing further scandal than with providing high-quality medical care, and the VA's isolation from the rest of American medicine. The VA's administrators in Washington, Deutsch reported, were "dollar honest" but incompetent at overseeing medical care (Deutsch 1945a).

PM, SUNDAY, JANUARY 7, 1945

THE NATION

By Albert Deutsch:

Vets' Setup Needs Revamping Now to Avert Scandal

Study Shows Many 'Dollar Honest' Executives Are Incompetent

Some 15,000,000 men and women will have been in and out of the military service of the U. S. A. by the time the war ends. The Nation's future health and welfare is intimately tied up with the after-service fate of these veterans. They, together with their families – comprising about one-third the population – and some 4,500,000 vets of World War I, are all actual or potential beneficiaries of that gigantic rapidly-growing governmental mechanism known as the Veterans Administration.

I have just completed a study of the Veterans Administration (VA) covering a period of some three months. My interest has been especially directed to medical activities. I have talked to a score of VA officials, from Administrator Frank T. Hines down, to many rank-and-file VA employes, to doctors in and out of the organization, and to representatives of veterans' groups. I have visited several VA facilities (as the institutions are known), two of them within the past three weeks.

veterans entitled to Government assistance. There are other factors involved.

Here are some of those other factors in the present administration of veteran affairs, as I found them:

¶ Dollar-honest but incompetent executives.

¶ A colossal bureaucracy—tremendously expanded by the GI Bill of Rights and other recent veteran legislation – stricken with creeping paralysis in the face of a monumental task.

¶ The tangling of human destinies in an excessive mass of red tape.

Along with some 1,500,000 World War II vets, these discharged soldiers shown at the Fort Dix, N. J., Separation Center come under the supervision of the Veterans Administration when they leave military service. The Administration handles mustering-out pay, pensions, unemployment compensation, job finding, medical care, life insurance and other benefits to which 15,000,000 vets will be entitled by the end of the war. *Photo by Morris Gordon, PM*

Deutsch in *PM*, January 7, 1945.

The scandal that Maisel's and Deutsch's reporting predicted (and helped provoke) came to pass a few months later, when House Resolution 192 authorized an investigation of the

Veterans Administration. From May 15, 1945 through October 1, 1945, the Committee on World War Veterans' Legislation heard testimony about whether the VA was equipped to provide high-quality modern medicine.[11] The transcribed testimony exceeded 3,000 pages. It included complaints extracted from letters written by veterans; it accounts for the exact number of employees (male and female) in different areas of each hospital; it lists (anonymized) veterans and their medical statuses. The scandal provoked the production of a mass of information, which subsequently became part of the public record.

The House committee that convened in 1945 solicited testimony from five doctors from outside of the VA, working in different specialties in Philadelphia, Chicago, Washington DC, and Madison, WI, each associated with a medical school or a professional association. The committee of doctors made three clear recommendations: 1) The VA should establish a Department of Medicine and grant it authority over hiring and firing doctors; 2) The VA should be decentralized; and 3) The VA should make better use of medical residents.

At the time of this committee's investigation, VA doctors were employed as federal civil servants, which meant that their appointments were effectively political appointments. The committee of academic physicians declared that this method of obtaining medical professional staff for the VA was unacceptable and "should be abandoned as soon as possible." In its place, they favored a new Department of Medicine and Surgery which would be responsible for all hiring and firing of clinicians, and which would operate somewhat independently from the VA executives in Washington (US Congress 1946, 45). The doctors also advocated for separating the VA into regional offices so that administrative business could be conducted locally, instead of in Washington. The VA's executives resisted, and testified to the necessity of keeping control in

[11] This committee was authorized in January 1924 as a standing committee of the House of Representatives. It is now the House Committee on Veterans Affairs (veterans.house.gov).

Washington, but in response, the civilian academic doctors made clear that their recommendation for a physician-run Department of Medicine and Surgery was not punitive or unique to a hierarchically-organized bureaucracy. Rather, it was the standard of medical practice at the time. One member of the medical advisory group, Dr. Malcom T. MacEachern of the American College of Surgeons, testified:

> Now I want you to get this: You [VA] are not having this reorganization because of a whole lot of stories which we do not have much knowledge about [stories of horrific conditions in VA hospitals, including physical abuse by staff]. You are having it as a trend of the times. In other words, we recognize that we must get on a new level (US Congress 1946, 46).

In response to the hearings, Congress established, in 1946, a Department of Medicine and Surgery under a VA Surgeon General and authorized the Department to staff the hospitals.[12] The entity created was the Department of Medicine and Surgery, which is now the Veterans Health Administration (VHA).[13]

The imperative to "get on a new level" was also the context in which the VA became a teaching hospital. During the 1945 hearings, the journalist Deutsch had reported—and then testified in front of the House committee—that the VA's low-quality care originated in part because the VA was isolated from the American medical profession. Deutsch showed that "organized medicine," headed by the American Medical Association (AMA), intentionally barred VA doctors from joining medical societies. The AMA's protection of its turf, combined with the VA's historically isolationist attitude, "fostered an unhealthy separation between

[12] Public Law 79-293, signed January 3, 1946, by President Truman.
[13] When the VA was made into a cabinet-level organization in 1988, the Department of Medicine and Surgery was re-designated as the Veterans Health Services and Research Administration, and eventually, in 1991, was renamed again to the Veterans Health Administration (VHA).

veterans and non-veterans, and kept veterans' institutions physically, socially and scientifically removed from community life" (Deutsch 1945b). The academic doctors convened by the House committee agreed with Deutsch, and one of the outcomes of the 1945 House committee hearings that shaped how the VA looks today was the physicians' insistence that the shockingly bad care veterans received could be blamed on the VA's isolation from the rest of the medicine that was practiced in the country. The committee's suggestion that the VA decentralize the hiring and firing of doctors was accompanied by an additional measure for pushing the VA "to get on a new level" in its provision of modern medicine: the committee recommended an investment in research and academic medicine.

A partnership between the VA and the medical schools was beneficial for both parties. In the postwar years, American medical schools had a shortage of resources for medical research and training. These were resources the VA had, along with a newly independent Department of Medicine and Surgery (Moore 2015, 331-332). Between 1946 and 1951, successive sets of VA Administrators and Medical Directors created formal partnerships between American medical schools and the veterans' hospital system. Dr. Paul B. Magnuson, founder of the Rehabilitation Institute of Chicago and the VA's Medical Director from 1948 to 1951, was one of the academic physicians who brokered the deal. Magnuson wrote in his memoirs:

> I told [the deans of Harvard, Boston University, and Tufts] that we were going to build a hospital in Boston for the care of veterans, and that we would build it wherever the three of them felt it would be of the greatest service as a teaching hospital, and thereafter it would be up to them to staff it and put in programs that would insure first-class instruction to their residents in training (Magnuson 1960, 301, qtd. in Moore 2015, 332).

Under the new arrangement, the VA would share its facilities with universities, whose medical school faculty would be jointly appointed at VA hospitals, where they would train their students. The medical schools benefited from access to VA resources and patients, and the VA benefited from an improved reputation as a center for modern academic medicine. By the end of 1946, the VA had partnered with 63 of the country's 77 medical schools (Moore 2015, 332).

OPENING UP THE VA (1990S)

The two institutionalized changes that I described above—the shift from compensating disabled veterans to rehabilitating them, and the 1945 creation of an independent Department of Medicine and Surgery partnered with academic medicine—have persisted through generations. They are prominent features of today's VA and they paved the way for a third, more recent set of reforms: the transformation of the VA into an accountable care organization, with "a focus on populations rather than individuals" (Kizer 1995, 17).

In the mid-1990s, one of the major things debates in the larger American political scene was the push for health care reform,[14] with President Bill Clinton's administration advocating for universal health care.[15] The health care reform plans that were proposed to Congress maintained the VA's independence as a Cabinet-level agency, which meant that the VA would have to become integrated into the plan for the whole country. VA administrators at the time developed a

[14] Another major political move was welfare reform. In 1996, President Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act, commonly referred to as "welfare reform," which restructured the US welfare state (see Morgen and Maskovsky 2003). In a 2006 op-ed in The New York Times, Clinton recounted that at the time, Republicans and Democrats agreed on "shifting the emphasis from dependence to empowerment" (August 22, "How we ended welfare, together").

[15] As we were reminded during Hillary Clinton's 2016 presidential campaign, President Bill Clinton appointed Hillary Clinton to head the Task Force on National Health Care Reform in January 1993. The Task Force designed a universal health coverage plan that would use federal subsidies and "managed competition" (what we now know as the health care "marketplaces" under the Affordable Care Act) to extend health insurance to all Americans.

complementary plan to "open up" VA health care to groups of veterans who had not previously had access, such as veterans with health problems not related to military service. The effect would be to more fully incorporate the VA into the larger field of American health care, which would allow it to take in additional income from federal subsidies that were presumed to be on the horizon (Inglehart 1996).

The Clintons' proposed universal health care plan was debated through August 1994, when it eventually became clear that big business would not back the reforms. One former Democratic Congressman from New York was quoted in the *New York Times* as saying, "You are not going to reform one-seventh of the American economy without business support and Republican support" (August 28, 1994). Although the Democratic health reform plan failed, the Veterans Health Care Eligibility Reform Act of 1996 passed, and it established the eligibility rules that are still in place today. [16]

Before the 1996 eligibility reform, the VA was only authorized to care for veterans' service-related health conditions, and to provide for veterans who were poor or unable to work. Veterans with no service-connected disabilities were excluded from VA care, and veterans who had partial service-connection could only receive VA care for those specific injuries or illnesses. Under the Eligibility Reform Act, the VA continued to be *required* to provide all the care it had previously provided, but it *was also authorized* to provide care for other groups of veterans, assuming there were sufficient resources to do so. For instance, middle-class veterans whose care was financed by private insurance reimbursements would be allowed to use the VA, as would those covered by Medicare. This meant that the VA's patient population could increase, bringing with it more funds, while the Congressional appropriations to the VA's operating budget stayed

[16] The legislation revised Section 1710 in Title 38. It was Public Law 104-262.

constant (Moore 2015). The changes also meant that the VA would shift from being a network of hospitals that provided isolated care for veterans' service-connected conditions to being a primary care provider.

The responsibility for transforming the VA into an organization focused on primary care and disease prevention fell on VA Under Secretary for Health Dr. Kenneth W. Kizer, who is credited with envisioning the VA as what public health policymakers call an Accountable Care Organization—a health care system that provides coordinated care to a set group of patients with the goal of avoiding unnecessary duplication of services and preventing medical errors.[17] By Kizer's account, in the 1990s, VA medical care had once again become "highly dysfunctional":

> The quality of care was irregular; service was fragmented, disjointed, and insensitive to individual needs; inpatient care was overutilized; customer service was poor; and care was often difficult to access (patients sometimes traveled hundreds of miles or waited months for routine appointments) (Kizer and Dudley 2009, 316).

Even leaving aside moral obligations of doctors to provide high-quality care, reforms made sense from an administrative and budgetary perspective. Kizer writes,

> To be successful, the integrated health care system requires management of total costs; a focus on populations rather than individuals; and a data-driven, process-focused customer orientation (Kizer 1995, 17).

As an integrated healthcare system, the VA had unique characteristics. As journalist Philip Longman writes, "[in] contrast to even the largest HMOs, the VHA could count on a relatively

[17] Accountable Care Organization is a term used to describe coordinated care for Medicaid patients (www.cms.gov/medicare/medicare-fee-for-service-payment/aco/), and journalist Philip Longman (2007) uses it to refer to the VHA.

stable population of patients, which in turn gave it a built-in case for pursuing quality" (Longman 2007, 54). A private-sector Health Maintenance Organization's (HMO) patients are likely to switch insurers when their employment or life circumstances change, creating a disincentive to invest in preventative care. The VA, by contrast, keeps its patients for life, regardless of whether they move or change jobs—they simply move to another VA. In other words, "opening up" the VHA created a financial incentive to provide high-quality care because keeping its patient population healthy minimized the portion of the organization's budget their care consumed. Effective preventative medicine and efforts to reduce errors and wasted resources would extend the life of each year's advance appropriations from Congress.

The VA had another unique set of circumstances that facilitated Kizer's reforms. In the 1970's, a group of VA doctors had created a home-made computerized medical record that grew into the nationwide Veterans Information Systems and Technology Architecture (VistA) System, which combines clinical, financial, and administrative functions (Longman 2007, Chapter 3). Starting in 1995, VA doctors were expected to focus on prevention and early detection of chronic conditions (heart disease, hypertension, diabetes, obesity) as well as reducing tobacco and alcohol use (Kizer and Dudley 2009, 320). To implement such extensive screening and preventative care, VA administrators used the VA's data reporting systems to generate information about the care being delivered and compare it to existing metrics used in other hospital systems and Medicare. These efforts revealed, for instance, that only one percent of the VA's elderly male patients were being screened for prostate cancer at the time that Kizer took over as Under Secretary (Longman 2007, 51) and now the computer system reminds clinicians which patients are due for cancer screenings and other preventative care. Other examples of how the VA's early capacity for electronic medical recordkeeping made it possible to manage its

patient population include its quick responses to events that effect a subgroup of veterans. In 2005, for instance, pharmaceutical company Merck recalled an arthritis medication and the VA identified "which of its patients were on the drug, literally within minutes, and [switched] them to less dangerous substitutes within days" (Longman 2007, 39). The same year, there was a nationwide shortage of the flu vaccine, and VistA was used to identify which elderly veterans were most in need of flu vaccination (Longman 2007, 39). The VA's process of identifying which elderly veterans need a flu shot is an example of one of philosopher Ian Hacking's "engines of discovery" that point to exactly how the human sciences make people up (Hacking 2006, 9). Hacking names bureaucracy as an administrative engine: for better or worse, the VA picks out veterans with particular characteristics and organizes an intervention, much as school systems pick out children deemed to have developmental disabilities and assign them to special service (Hacking 2006, 12).

The VA's electronic medical record system is critical in the conception and implementation of these population-level interventions, and it forms the larger context of the VA's elaborate screening protocols for OEF/OIF veterans, which become important in subsequent chapters.

Rehabilitation clinicians at the Western VA

With this selected history of the VA, I have highlighted the inevitability of public scrutiny of the VA, the role of the VA's electronic medical record system in clinicians' tracking of veterans' health, and a seventy-year-old partnership between the VA and American medical schools. I have suggested that the context in which the clinicians I describe in this dissertation worked is characterized by two prominent features: uncertainty and medical education.

At present, VA medical facilities are affiliated with 171 of the nation's 181 medical schools (94 percent). Though the VA has never operated its own medical schools or residency programs, it is the largest provider of medical training in the country. In the 2014-2015 academic year, 25 percent of all medical students, residents, and fellows (more than 64,000 people) were training at a VA facility (Heisler and Panangala 2016, 1). Among resident physicians alone, nearly 35 percent (41,223 people) were trained in programs that partner with the VA (Heisler and Panangala 2016, 1).[18]

The Western VA's primary university affiliation was with an elite medical school located about a mile away from the VA's campus. I refer to the medical school as the University, in part to maintain the anonymity of the Western VA. The generic name also signals that this VA-academic partnership is not unique to this setting—this is how VA hospitals all over the country are organized (cf. Rhodes' [1991] study of a psychiatric emergency unit where doctors have an ambivalent relationship to the generically-named University with which their hospital is affiliated). Some of the clinicians whose stories appear in this dissertation were resident physicians completing advanced training funded by the University; others were attending physicians supervising the residents or postdoctoral researchers working in VA fellowship positions funded by the VA. Those clinicians who were not involved directly in training programs (nurses, social workers, and therapists) worked in teams with medical residents.

In the context of this partnership between the VA and the University, Drs. Elena Beech and Mara Danzig were attending physicians, responsible for supervising and mentoring resident physicians and fellows. During my fieldwork, Elena ran the TBI Clinic with the help of two

[18] The VA claims an even higher number of medical residents are trained at VA hospitals: "Roughly 60 percent of all medical residents obtain a portion of their training at VA hospitals; and VA medical research programs benefit society at-large" (www.va.gov/about_va/vahistory.asp).

other attending physicians and a cohort of eight residents, including Drs. John Moy and Leila Fredrick, who I will introduce later. John, Leila, and their colleagues were in the final year of a three-year residency program in rehabilitation medicine. They rotated through clinics at the Western VA as part of their training to become physiatrists, doctors specializing in the prevention, diagnosis, treatment, and rehabilitation of disorders that produce temporary or permanent functional impairment. Functional impairments, for example, are blindness and deafness, which affect the senses, and paralysis and tremors, which affect mobility and communication. Physiatrists work in teams with orthopedic surgeons, prosthetists, neurologists, neuropsychologists, speech and language pathologists, physical therapists, occupational therapists, and social workers toward the shared goal of enabling "persons with disabilities to interact with their environments and maintain optimal physical, sensory, intellectual, psychological, and social function levels" (Albrecht 2015, 148). Therefore, in addition to being teachers and mentors and students and doctors, Elena and Mara and their colleagues are crucial participants in the first pivotal reform I described in this chapter, the institutionalization of the fantasy of rehabilitation.

Along with the doctors, veterans' participation is also required for this fantasy to persist. The veteran's role is to access and use VA services. In their studies of governmentality, Miller and Rose (2008) focus on techniques instead of the subjectivity produced by the techniques, and they show that there are no universal subjects of government—that is, techniques of government produce many subjectivities. Miller and Rose write:

> Those to be governed can be conceived of as children to be educated, members of a flock to be led, souls to be saved, or, we can now add, social subjects to be accorded their rights and obligations, autonomous individual to be assisted in

> realizing their potential through their own free choice, or potential threats to be analysed in logics of risk and security (Miller and Rose 2008, 7-8).

Following Miller and Rose's framework, the specific post-military subjectivity veterans adopt is not the issue; what matters is that they are awarded their benefits and assisted in their rehabilitation. In the introduction to this chapter, I quoted a retired Brig. General who suggested that if the country neglects the combat-related illnesses of yet another generation of veterans, as it did after the war in Vietnam, then it may be impossible to "ask young people to fight for us again." Why is it the post-injury *neglect* that matters, and not the circumstances of the original harm? Linker's (2011) analysis of the institutionalized fantasy of rehabilitation shows why it is critical that veterans' injuries not be neglected: the fantasy that war wounds can be erased through rehabilitation is a necessary part of the bargain of making war.

Conclusion

Throughout its one-hundred-year history, the VA's institutional shape has been formed around scandals provoked when its failures came to the attention of the public. The VA's predecessor institution had problems with fraud, which brought about a military-style hierarchical organization, heavily centralized in Washington, DC. When that centralization was found to be inefficient and intellectually isolating, the VA was decentralized so that it more closely resembled a private-sector hospital system. Throughout, investigative journalists have documented and publicized the VA's problems, a process that has often resulted in the formation of Congressional committees to further investigate and propose solutions. These reforms in the VA's history have, likewise, generated new technologies for creating and using information, such as the computerized patient record system (CPRS) and VistA, and new technologies for

conceptualizing populations of veterans and their needs, such as the policies associated with "opening up" the VA and transforming it into an accountable care organization.

The VA's institutional history shows *why* veterans are subjects who need to be accorded their rights: they are part of the larger rehabilitative fantasy of war without causalities. In this chapter, I introduced two related themes that extend through the rest of the dissertation: first, the federal government's responsibility for veterans' rehabilitation, and second, the fantasy of war without casualties, introduced here as a Progressive-Era ideal that war wounds could be "healed, and thus forgotten" (Linker 2011, 7). Upholding this rehabilitative fantasy becomes both the responsibility and the legacy of VA clinicians. In subsequent chapters, I show how these various technologies are used—by clinicians—for keeping track of veterans as a group, specifically in the case of mild traumatic brain injury. The rest of the dissertation shows *how* clinicians in the contemporary VA become involved in the larger process of maintaining the rehabilitative fantasy and veterans are brought into the VA to be accorded their rights.

CHAPTER 2. INSTITUTIONAL BAIT-AND-SWITCH

> It's really not accurate to just blame one part of the brain for difficulties you're having.
>
> Cifu and Blake 2011, 153

> Each and every classification engages some social perspectives and shuts down others.
>
> Jutel 2011, 38

This chapter concerns the parts of veterans' post-military lives that mild TBI obscures. "Signature injuries" are powerful symbols of the deep entanglement and mutual productivity of wounding technologies, protecting technologies, and healing technologies, and in the sense that they situate physical and psychological harm in the context in which the harm occurred, they are not strictly medicalized categories. However, they also name trauma that affects soldiers' bodies, and while naming combat-related mild TBI a "signature injury" illuminates certain circumstances of war, focusing on the injury alone obscures a great deal of non-traumatic aspects of life in the military, and life after the military.

In this chapter, I analyze veterans' memories of leaving the military and beginning a new civilian life. I discuss the difficulties that veterans have with mundane things, such as adjusting to family life and settling into post-military careers. These difficulties are grouped together by clinical researchers as trouble with the "transition" from military to civilian life. My discussion of veterans' health in this register draws on and contributes to health anthropologists' movements to "demedicalize" their ethnographic analyses of people's health and illness, as well as the anthropological literature on military service members' and veterans' experiences.

There is a secondary question that drives this chapter. Throughout my research, I was puzzled by the relationship between the military and the VA. In strictly organizational terms, the two are entirely separate Cabinet-level departments of the federal government. My observation of both military and VA settings throughout my fieldwork suggested the most substantial connection between the two institutional settings was in the people who move between them—service members enter the military, become soldiers or sailors or Marines, and upon exiting the military, become veterans and start using the VA. In fact, the VA's mission—the institutionalized rehabilitative fantasy around which the VA is organized—resides in those people. When service members become veterans, the VA inherits whatever happened to those people during their time in the military and becomes responsible, in some sense, for erasing it through stabilization and rehabilitation. In the most straightforward terms, the VA is responsible for taking the fall for the military's destruction of human bodies and lives. What puzzled me during my fieldwork was veterans' relationship to the VA— veterans themselves did not appear to have any meaningful connection to the institution, and yet veterans and their rehabilitation seemed to be vitally important to the VA. I asked veterans many times about why they used the VA, and without exception they provided a wholly practical answer—VA care was free.

Here, I interpret veterans' perspectives on leaving the military to show how VA services can be understood as a kind of bait and switch. My analysis highlights veterans' idealized memories of their participation in the institution of the military—the institution with which they signed a contract, the institution that issued their paychecks and structured the mundane parts of their lives for years. When military service ends, so does this relationship. Therefore, when we consider the VA and its effectiveness, I suggest that we notice how the VA is responsible for maintaining a relationship that, for veterans, began with the military—an entirely different institution and one to which they no longer belong. This recognition might shape our understanding of the VA and our appraisal of how it performs its many tasks.

WHAT MEDICAL DIAGNOSIS OBSCURES

In 1972, Irving Zola observed that medicine was becoming a major institution of social control, alongside the traditional institutions of religion and law. Medicalization refers generally to medicine's influence on society and, as Zola suggests "not merely that medicine has extended its jurisdiction to cover new problems, or that doctors are professionally committed to finding disease, nor even that society keeps creating disease" (497) but also "belief in the omnipresence of disorder" (Zola 1972, 498). In reviewing medicine's history as an institution of social control, Margaret Lock (2004) points out that in the 18th and 19th centuries, medicine expanded its purview beyond individual pathology to "life-cycle events," beginning with birth in the early 18th century in Europe and North America, followed by the medicalization of adolescence, menopause, aging, and death, and finally, in the 20th century, infancy (Lock 2004, 117). The expanding domain of medicine was paralleled by the emergence of the forms of power Foucault (2007) called "governmentality," whereby "medicine was integrated into an extensive network

whose function was to regulate the health and moral behavior of entire populations" (Lock 2004, 117). Medicalization is a social process that enables (and depends on) certain kinds of classification, surveillance, and discipline—those changes in perception and discipline that Foucault describes in *Birth of the Clinic* (1973) and *Discipline and Punish* (1977). Medicalization depends on processes by which "sickness is distinguished from health, illness from crime, madness from sanity, and so on. With this type of reasoning certain persons and populations are made into objects of medical attention and distinguished from others who are subjected to different authorities including the law, religion, or education" (Lock 2004, 118). What these scholars describe is a sweeping social process, and its effects on multiple domains of social life: knowledge, forms of control, and how we conceptualize ourselves as people.

This larger context of medicalization shapes people's behavior and their relationship to themselves, a process that Nikolas Rose refers to as a transformation in personhood. In the 20th century, people developed a sense of themselves as *psychological* individuals, "beings inhabited by a deep internal space shaped by biography and experience" (Rose 2003, 54). Psychological individuals, Rose argues, are now becoming *somatic* individuals. This new way of relating to oneself and others is defined by "the tendency to define key aspects of one's individuality in bodily terms," and specifically, to understand the body in the language of contemporary biomedicine (ibid). The formerly-dominant psychological self has yielded ground to the physiological self:

> While discontents might previously have been mapped onto a psychological space—the space of neurosis, repression, psychological trauma—they are now mapped upon the body itself, or one particular organ of the body—the brain (Rose 2003, 54).

Much of this dissertation is about how a group of veterans maps discontents onto their brains, and why and how VA clinicians endeavor to prevent veterans from doing that. A primary reason that clinicians avoid adopting a fully somatic approach to veterans' cognitive problems is because such an approach is limiting.

My focus in this chapter is on the parts of veterans' lives that medical categories obscure, and it is helpful to draw on ethnographic accounts of the "demedicalization" of certain aspects of life. Emily Wentzell, for instance, shows that some elderly Mexican men reject pharmaceutical solutions to erectile dysfunction, and in doing so, they develop alternative ideas about healthy aging that do not medicalize aging (Wentzell 2013). We can also see the decentering of medicalized interventions in parts of a conversation in anthropology about what constitutes "care" (e.g. Mol et al. 2010). Anthropologists have recently produced many examples of "care" that are not strictly biomedical therapies. For example, Marieke van Eijk shows that clinicians in a transgender clinic perform a kind of "clinical-administrative" labor through which they mobilize their knowledge of insurance to tailor care (van Eijk 2017), and Elana Buch describes how home aides caring for elderly clients use their own bodies' abilities to taste and smell in efforts to sustain the personhood of those in their care (Buch 2013).

Moving further away from the domain of traditional, clinic-based biomedicine, Emily Yates-Doerr and Megan Carney, in their research on health in Latin America, show how food preparation and cooking point to a "prescriptive dissonance" that accompanies clinic-based health care. Clinical care is aimed at producing immediate and measurable effects in the individual body; by contrast, the culinary care they observe "treats the fracturing of families, land contamination, the fragility of spirits, the maladies of border politics" (Yates-Doerr and Carney 2016, 316). Their demedicalized understanding, Yates-Doerr and Carney argue, helps to

expand and diversify both clinical and anthropological inquiries into what constitutes health, and what interventions should be in place to support it (Yates-Doerr and Carney 2016, 317).

In a move similar to Yates-Doerr and Carney's demedicalized perspective on health, anthropologists who study militaries and veterans have also shown the value in including families, communities, and politics in their analyses. For example, Sarah Hautzinger and Jean Scandlyn (2014) show that war's effects reverberate well beyond the individual soldiers involved, affecting communities in a pluralistic maze of complex ways which cannot be contained within a single medical diagnosis, nor within individual soldiers' bodies. Erin Finley's (2011) ethnography of PTSD in the post-9/11 era shows that veterans' experiences of PTSD are relational, constituted in communities and families. These ethnographic accounts reconceptualize trauma so that it is recognizable outside of the individual psyche. Other ethnographies have productively focused on aspects of soldiers' experiences that are not trauma, most notably Kenneth MacLeish's (2013) account of precarity and daily life on a military base in Texas. Together, this research concerns military service members' health—in its broadest, most demedicalized sense.

Medical diagnoses—like classifications of all sorts—segment the world and in doing so they necessarily include some things and leave others out (Bowker and Star 1999). Writing about medical diagnosis as a form of classification, sociologist Annemarie Jutel writes, "each and every classification engages some social perspectives and shuts down others" (Jutel 2011, 38). Hautzinger and Scandlyn's (2014), Finley's (2011), and MacLeish's (2013) ethnographies of military communities and military families provide insight into what happens beyond the boundaries of labels like "PTSD." Combat violence and its immediate effects often draw our attention—they are the primary trope for understanding soldiers' experiences. However, not all

of veterans' post-military experiences are caused by combat-related trauma. Research in anthropology and other fields has shown that many of veterans' post-military struggles in the civilian world are made up of experiences that are hard to describe, ambiguous in cause, transitory in nature, and therefore not easily categorized. In contemporary popular and clinical discourse, these non-medical post-combat experiences have been referred to as part of the "transition" from being a service member to being a veteran.

TRANSITION

The veterans who participated in this research were among the 1.9 million veterans who served in the wars in Afghanistan (OEF) and Iraq (OIF/OND) and became eligible for VA services between 2002 and 2015 (US Department of Veterans Affairs 2017). More than three quarters of the OEF/OIF/OND veterans who have enrolled in the VA are under the age of thirty-six, and more than half of them are under twenty-six years old (US Department of Veterans Affairs 2017). In 2015, they constituted about a quarter (27 percent) of the VA's 9.6 million users (National Center for Veterans Analysis and Statistics 2016). In broad strokes, this is a population of young veterans who are simultaneously finding new jobs, establishing new daily routines, and taking on new challenges like earning college degrees. Exiting the military can also mean relocating, living independently for the first time, reuniting with a partner and children after long periods overseas, or becoming a parent. These major life changes are challenging for military veterans, just as they are challenging for anyone. The challenges associated with these changes are not easily studied by biomedical researchers, in part because they are not captured by medical diagnoses, and in part because it is difficult to draw meaningful lines between

physiological, psychological, and social problems. Moreover, the mundane matters of everyday life tend to be overshadowed by veterans' other, more extreme, experiences in combat.

The veterans I interviewed were ranked as non-commissioned officers (E-4 or E-5) in their respective military branches. They worked as truck drivers, air traffic controllers, infantry assaultman, combat engineers, military police, medics, and snipers. As a population, enlisted service members are younger than officers. Many enlisted service members do not have college degrees when they join the military. For example, in 2008, the year in which the highest concentration of US troops deployed overseas, 52 percent of enlisted service members were 25 years old or younger, and only 4.5 percent had a bachelor's degree (US Department of Defense 2008).

Most of the veterans who participated in my research were not medically discharged from the military, and served out their four-, five-, or six-year contacts. Few were in the military for more than eight years.[19] The relatively short duration of their time in the military meant that their work experience was limited to one or two jobs, they did not pursue higher education during their time in the military, and they were on their own at the end of the contracts.[20]

Therefore, for these lower-ranking soldiers, sailors, and Marines, returning to the United States after an overseas deployment to a combat zone likely *also* coincides with the end of a relatively short military contract. This meant that they had to manage, simultaneously, the physical and psychological aftermath of their combat experiences *and* changing jobs. Between 2014 and 2016, between 65 percent and 80 percent of veterans surveyed by a team of researchers

[19] I did not collect this information from every veteran who participated in my research. For those veterans about whom I have such data, their time in the military was as follows: two veterans spent two years enlisted; three veterans spent four years enlisted; five veterans spent five years enlisted; three veterans spent six years enlisted; four veterans spent eight years enlisted; two veterans spent ten years enlisted.

[20] Military retirement is paid only to people who have served for twenty years.

at the University of Southern California left the military without a job, expecting to find meaningful employment quickly (Castro, Kintzle, and Hassan 2014; Kintzle, Rasheed, and Castro 2016), and yet, in 2008, fewer than five percent of US service members had a bachelor's degree (US Department of Defense 2008). When service members exit the military, they need new social identities, new aspirations, new communities, and new careers.

Even a brief time in the military can be formative. The military is a quintessentially disciplinary institution (Foucault [1977]1995), and as MacLeish writes, "soldiers are caught in the middle of some of the most restrictive, overdetermining, and glaringly vulgar power structures that it is possible to conceive of" (MacLeish 2013, 14). And as Marine Corps Major General Smedley Butler wrote after World War I, in making his famous argument that "War is a Racket!", the military does an extremely effective job of training people to operate within the military, and an extremely poor job preparing them to resume civilian life. In 1934, Butler wrote:

> Boys with a normal viewpoint were taken out of the fields and offices and factories and classrooms and put into the ranks. There they were remolded; they were made over; they were made to "about face," to regard murder as the order of the day. They were put shoulder to shoulder and, through mass psychology, they were made into machines for slaughter. We trained them to kill other men with nonchalance and dispatch. We used them a couple of years.
>
> Then, suddenly, we discharged them and told them to make another "about face." Only this time they had to do their own readjusting, without mass psychology, without officers' aid and advice, without nation-wide propaganda. We turned them loose without three-minute speeches, without parades. Many, too

> many, of these fine young boys are eventually destroyed, mentally, because they could not make that final "about face" alone (Butler 1934, 142).

Butler critiques the military and the nation for shaping soldiers' bodies and minds to fit the needs of the institution without regard for how they would fare outside of the military. In the rest of this chapter, I draw on my interviews with Western VA veterans who reflected on what it was like to "do their own readjusting" after being so thoroughly disciplined by the military.

Veterans' reflections on their departures from the military are only peripherally related to combat, and only in so far as combat is the *raison d'être* of the institution they describe. Here, my focus is on veterans' impression of their (former) relationship with the military as an institution. In their accounts of themselves as service members and their experiences leaving, I highlight three dimensions of their relationship with the military that mattered to them: their contracts; an ideal of unity and reciprocity, and an ideal of transparency in their relationship with the military. Contrary to accounts that foreground violence and trauma, veterans paint a picture of the military as a predictable and stable place. This, I think, should make us wonder what it's like to leave. I am not arguing that violence and trauma do not matter, but I am following these veterans' lead in taking seriously the proposition that there are aspects of military life that are difficult to part with.

THE MUNDANE CHALLENGES OF TRANSITION

Veterans' descriptions of leaving the military highlight the intersecting stressors of unemployment, loneliness, and the abrupt change of leaving an all-encompassing institution to which they had been attached for years. One veteran, for instance, remembered that his biggest concern when he left the Army was about financial instability:

> When you're getting out, the biggest challenge is: what am I going to do? How am I going to live? Even the chain of command [recognizes] the challenges people who are leaving face. In the Army it's a stable paycheck, health benefits. When you're leaving the biggest question is: how are you going to make your living?
>
> – Thirty-three-year-old male veteran, two years after leaving the Army

This veteran had planned his departure from the Army, and yet his new path was accompanied by uncertainties. He echoed the sentiments of veterans surveyed by other researchers in 2008, who reported feeling as if they were starting over with their career (Kintzle, Rasheed, and Castro 2016).

Veterans also experienced an unanticipated solitude after leaving the military. One veteran described how strange it was when military service ended and people who had lived and worked together for years dispersed across the country:

> We went to boot camp at the same time. We were in the same company. We went to [infantry training] together, and the rest of our four years [in the Marines], we were roommates. You live with someone. You work with someone. And then one day you just leave. It's kind of weird. When you're in the military they pull you from all these different parts of the country. When you split up, it's not like I can just drive a couple of miles and hang out with my friends that were in the Marine Corps with me. He's going back to Kentucky. He's going to Florida. He's going to Georgia.

Another veteran expressed a similar memory of being suddenly no longer part of an intimate group. Recounting the difficulty of leaving friends and co-workers, he said:

> You're with people, you're with them every day. Like literally every minute, of every day, for years. And then, all of a sudden, they're just all gone. It was hard.
>
> – Thirty-eight-year-old male veteran, eleven years after leaving the Army

The intimacy between service members that these two veterans remember quickly slips into glorification of the military as a unique social context in which life-and-death experiences foster an interpersonal bond that is inaccessible in everyday civilian life (e.g. Junger and Hetherington 2010, Junger 2016). In depictions that foreground the unique social bonds between service members, the military itself—the larger institution in which these bonds are formed—fades into the background, and we see only the relationships between the men. By contrast, my data points to veterans' reflections on the institution in which they had once been members. For example, echoing the veterans quoted above, one Marine Corps veteran who had been in the military for ten years described leaving the military as "weird" because the bonds that he had forged with other people seemed to be suddenly broken. The base where he'd been stationed was near his home, and after he had been medically discharged, he tried to go back to the base—his workplace for a decade. In his story, the military's authority to delimit its own boundaries featured more prominently than the friends he missed:

> If you try to go back and say, "Hey, I want to say 'hi' to my friends!" they're like, "No, you're not allowed here. You're now what we call a civilian and you're an outsider. You're not allowed here anymore. Get out of here." So, it's a weird transition. I understand it… but there's no real transitional period.
>
> – Male veteran, seven years after leaving the Marine Corps

In this veteran's memory, the Marine Corps itself is present, actively forcing him to recognize his new subject position as a civilian—that is, no longer a Marine. As he tells it, his access to his friends was interrupted by the Marine Corps and its strict distinction between inside and outside.

When service members become veterans, their social environment changes suddenly. This recognition has been productive for thinking differently about veterans' personal difficulties in ways that do not rely on physical trauma, psychological trauma, and individual pathology. But what does this sudden change—and veterans' interpretations of it—reveal about the VA as an institution?

The Department of Defense and the Department of Veterans Affairs are separate, but they are symbolically joined by narratives of patriotism, responsibility, and morality. Here I offer an analysis of veterans' idealized versions of their former relationship with the military. This is not an analysis of veterans' experiences with the VA, as such. Rather, I am concerned with veterans' retrospective reflections on the military, what those reflections mean for their engagement with the VA, and how these perspectives might change the way we think of the VA as an institution.

I asked all of the veterans I interviewed to tell me about leaving the military. Each answered by telling me what they liked and missed about the military, and some of the ways their life in the military had bored or disappointed them. Veterans' stories about leaving the military also shared two themes that I highlight here: first, veterans spoke about teamwork. They described their time in the military as participation in a unified team that worked together in service of larger goals. Their descriptions evoke a sense of being part of something larger than oneself. Second, veterans described a kind of reciprocity. When they were in the military, they had obligations and responsibilities, and so did the military. Each's responsibility was defined in a contract, which veterans experienced as indicating a kind of transparency and reliability,

despite the vast power disparity between the two parties contractually connected. The military's reach into every part of its members' lives was justified by this idealized reciprocity. Further, when people were involved in the military, their relationship to the state seemed to be participatory.

I argue that these idealized memories of teamwork, transparency, and contractual agreements with the military point to an institutional bait-and-switch. When military service ends, so does this idealized relationship. No longer active participants in a contractual relationship with the military, veterans collect entitlements from the federal government, through the VA. The end of the reciprocity shifts the nature of the relationship between these veterans, the state, and its agencies. Service members made a bargain with the military, and the VA fulfills the parts of the bargain that are outstanding when those people become veterans. The VA's task of fulfilling the promises made by the military (an institution with completely different characteristics) results in some of the tensions and contradictions that we see when we look at the VA, such as an apparent lack of "cultural consonance" between veterans and the VA, and some veterans' rejection of their earned benefits (Hooyer 2015).

IDEALIZED UNITY

In his book of essays titled *Redeployment* (2014), Phil Klay, himself a combat veteran, writes a character who was an officer in the Marine Corps. While deployed to Iraq, the character worked an office job. The former officer narrates, "My Iraq was a stack of papers. Excel spreadsheets. A window full of sandbags behind a cheap desk" (Klay 2014, 238). The fictional Marine does not have much in common with the veterans whose stories appear in this ethnography, but Klay's character uses a metaphor to describe the Marine Corps that captures the

sense of teamwork oriented toward a larger goal that I am highlighting here. Klay's Marine compares the Marine Corps to a colony of termites. Explaining the Marines to a friend who is an investment banker, the veteran says that given a pile of dirt, two individual termites will roll the dirt into balls and move it around, to no effect. Two termites build nothing. The towering structure of the termite mound only comes into being when the termites reach a critical mass:

> 'They're little Sisyphuses,' I said, 'with their little balls of dirt. I'm sure for a termite, it's a regular old existential crisis.'
>
> 'Maybe they need a termitess.' This is Ed-the-banker's solution to most problems, and it's generally not a bad solution.
>
> 'They need more termites,' I said. 'Two won't cut it. If they had enough brain cells to feel, they'd feel lost, awash in the loneliness in the heart of the universe or whatever. Nothing to depend on. Just dirt and each other. Two won't cut it.'
>
> 'So what? *Ménage à trois*?'
>
> 'It doesn't help to add only a few more termites. You might get piles of dirt, but the behavior is still purposeless.'
>
> 'To you,' Ed-the-banker said. 'Maybe pushing around little balls of dirt is like, the termite version of watching Internet porn.'
>
> 'No,' I said, 'they're not excited until you start adding more and more termites. Eventually you reach a critical mass, though, enough of the little fuckers to really do something. The termites get excited, and they get to work. […] Bits of earth stacked on bits of earth, forming columns, arches, termites on both sides building toward one another. It's all perfect […] As though there's a blueprint. Or

> an architect. And the columns reach each other, touching, forming chambers, and the termites connect chamber to chamber, form a hive, a home.'
>
> 'Which would be the Marine Corps,' Ed-the-banker said.
>
> 'Two hundred thousand workers all yoked to the same goal. Two hundred thousand workers risking their lives for that goal.'
>
> 'Which would make the civilian world—'
>
> 'A bunch of lone little animals, pushing their balls of dirt around" (Klay 2014, 262-263).

Klay's character idealizes the Marines as a collective. Alone, each person only rolls tiny balls of dirt; together, they produce something big enough and important enough to risk their lives for. The larger goal might be any combination of patriotism, imperialism, suppression of terrorism, protection, or liberation—it does not particularly matter. Individual service members have different relationships to the larger ideals.

For instance, I interviewed a thirty-two-year-old veteran of the Marine Corps. At the time, he was applying to work at the Fire Department. When I asked him why he joined the Marines, he said:

> I thought it would be interesting to try to help people. You know, help people become free, to get out from under an oppressor. I thought that would be an amazing thing to be a part of.
>
> – Thirty-two-year old male veteran, three years after leaving the Marine Corps

Another veteran, also in his early thirties, echoed this desire to be a part of a group that was helping:

> So much of my career [has been] going from one uniform to the other. I want to have a different career [but] I think what's hard about it [switching careers] is this sense of… I don't know… the sense of being needed, you know?
>
> – Thirty-three-year old male veteran, eight years after leaving the Navy

When veterans reflected on their time in the military, they spoke about a larger sense of purpose in general terms, and Klay's termites are evocative of this otherwise unspecified larger sense of purpose that is attached to being part of an institutional machine that grinds toward some shared goal. For example, a thirty-two-year-old Air Force veteran described the process of learning to work as part of a team in this manner. She said:

> The military spends six, ten, twelve weeks training you to be a unit – not a person, but a unit—a cog in the machine.
>
> – Thirty-two-year old female veteran, seven years after leaving the Air Force

She went on to explain that in basic training, you learn to be selfless, and to understand how to operate in a communal network. Being part of the team requires personal sacrifices, she said, but the "reward" is that the team never throws away its weakest link:

> You know, I hear so many people talk about military training as "brainwashing." I don't think that's what it is. You have the same thing on a school football team, on a cheerleading squad, even an academic decathlon. There are stakes involved outside of yourself. And I don't think it's a bad thing to learn a little selflessness, and I don't think that's brainwashing. To have to consider other people besides yourself would probably benefit a lot of people in this country.

I asked her, "What do you think they teach you in basic training? What do you learn?"

"Selflessness!" She responded, smiling. "At the end of the day, all activities in basic training are to understand the network that you're now in."

"And how do they do that?"

"If one person is in trouble, everyone is in trouble. If one person fails, everyone fails. You're only as strong as the weakest link. But never at any point do we toss away or dismiss the weakest link."

This ideal, unified team is made possible by the military's encompassing structure, which sustains its needs. The stakes of successfully operating as a unified machine are life-and-death, and thus the necessity of the effective team is part of what justifies the military's reach into every part of servicemembers' lives.

For some, the military's unlimited reach feels like being perpetually on-call. One veteran explained his realization that he was never *not* responsible for his position in the team:

> I mean, it may feel like a job while you're doing it, but then you realize, even when you're sleeping, you're on duty and on call.

Another veteran remembered being stationed in Kansas. He knew that if a dangerous storm rolled in around seven-o'clock in the evening, there would still be soldiers out in the field, and soon he would hear a knock on his door from an officer who would tell him to get back to work:

> We have to go get these soldiers from the field, it's not safe for them to be out there. And you're given a command. It's not an option.

Then he laughed, and told me that eventually, he did learn to not pick up the phone, "but if they show up at your door, you have to go." This was an example of the absence of boundaries between work and his personal life. For this veteran, showing up as part of the team was an obligation:

> [The chain of command made] it feel like an obligation, like this [what the military needs] is more important. This comes first.
>
> – Thirty-five-year old veteran, two years after leaving the Army

The military's needs come before service members' individual needs because adopting the full-time identity of being a service member is part of the job:

> You're a Marine twenty-four-seven. For the most part when you're working in a fleet it's like a normal job. You have a time when you show up to work and a time when you get off. But you're still a Marine, so if you go out on the town and do something, you're held liable to that through the Marine Corps and the [Uniformed Code of Military Justice].
>
> – Thirty-two-year old male veteran, three years after leaving the Marine Corps

Not only are servicemembers obligated to come when they are summoned, but the military is the exemplary disciplinary institution. Veterans described military discipline as spun through care, surveillance, and the institution's power to punish them by rescinding their earned status and benefits. In an interview, one veteran reflected on why he thought the military requires its commanders to reach into parts of everyday life that seem unconnected to military work. He thought the encompassing reach of the military was best explained by its investment in its personnel:

> The military is one of those things that is all-encompassing. It takes care of you completely. It's not like any other job because you're completely taken care of. They give you clothes. They give you food. They give you money for rent. They take other things into consideration. If you get married, then you get extra money. If you have a kid, you get extra money. You can get extra money to live off-base.

> And some guys get pissed off because they get all up in your business, because technically your [commander], they're supposed to be in your life. If you're junior, they're supposed to know that your finances are straightened away. What other job out there can actually reprimand you if you bounce a check? But in the military, if you bounce a check, oh man! You can get in a lot of trouble! A lot of trouble!

"What do they care?" I asked.

> Oh, they care! Because you're government property. And if you're not taking care of yourself, be it physical or financial, then that's an issue. So, the military has its hands in every aspect of your life.
>
> – Thirty-year-old male veteran, five years after leaving the Marine Corps

In this view, the military is different from any other kind of work because of its reach into all aspects of life. Some effects of the institution's reach are ostensibly stabilizing and supportive, such as the access to regular income and affordable housing. But because there is no part of service members' lives that are outside to the military's domain, veterans remembered the possibility of punishment as constant, and talked about the military's disciplinary power and surveillance in terms of the threat of being punished for any action, regardless of where and when the infraction occurs (or who brings it to the military's attention). One Navy veteran put this discipline into perspective with a rhetorical question:

> I mean, what job have you worked at that's twenty-four hours a day, seven-days a week? [What job have you worked at in which] if you get in trouble, the newspaper reports *Sailor: Drunk Driving*?

We never see newspaper headlines, he observed, notifying us that: *Walmart Employee Got in a Car Accident.* Explaining the extent of the military's reach into his life, he continued:

> This [the Navy] is not a job. This is your life. You signed a contract. There's no easy way out of it. You can't quit. No. That's gonna be a federal problem. Little things can get you screwed up. If you get a DUI in the military, you get kicked out on a dishonorable discharge. Now you've got no VA benefits. You lose your GI Bill, possibly. Everything you thought you were working towards is lost.

When this veteran spoke about the benefits he feared he would lose, he raised the matter of his contract with the Navy. He signed a contract that there was no easy way to exit. Once he signed it, there were multiple incentives to uphold his end of the deal: protecting his rank and pay grade while was still in the military and, looking ahead to his post-military life as a veteran, protecting his federal benefits. In exchange for his participation in this contractual relationship, he was promised transparency in his advancement through the ranks and benefits upon completion of his contract. All of this, he feared, could be lost over something that he believes wouldn't have such serious consequences for a civilian.

THE CONTRACTUAL RELATIONSHIP

In veterans' reflections about their contractual relationship to the military, we see a relationship portrayed as if it is mutual. The control that the military exerts over its personnel seems to be justified by its responsibility for their wellbeing. Speaking to me about VA benefits, another veteran invoked his contract with the military to express the expectation that when a soldier upholds their end of the deal, the military should do the same. As an example, he told me about a friend who failed a drug test and was consequently released early from his contract with

the penalty of being assigned a lower status upon his exit. One possible consequence of being discharged from the military with an unfavorable status is losing access to VA health care and benefits. The point of his story was to convey to me that if a service member upholds their contractual obligations, it is unjust and arbitrary to deny them access to VA services.

> When you join, you sign a contract. The government is responsible for holding up their end just like you're responsible for holding up your end. And if you served your time and you get out with a discharge that says you deserve certain things that are in your contract, then yeah, you should definitely get them. It's between [you] and the government. That's what the contract's for.
>
> – Thirty-two-year old male veteran, three years after leaving the Marine Corps

This statement— "that's what the contract's for"—suggests not only an ideal of transparency and some semblance of equality between the parties, but also an ideal of reciprocity: if you served your time, the government will give what it promised. The ideal of a reciprocal contract makes the whole enterprise of military service seem less exploitative. And when veterans are not able to access or use the entitlements they thought they were being promised because of bureaucratic red tape, the exploitative nature of the whole relationship is laid bare. But amazingly, the fantasy of a reciprocal relationship with the military seems not only applicable to time spent enlisted, but for some, also applicable to the indefinite future. The commitment (and identity) produced through the contract endures. For example, one veteran declared that he would reenlist if the need arose, allowing his contractual duty ("that's what I signed up for") to merge with his identity as a solider ("something that's instilled in me").

> I would reenlist. And if things were to happen, of course I would. I mean, that's my duty. That's what I signed up for. Yeah, I did my time. But if any war happened, I'd still feel like I was still obligated to. It's just something that's instilled in me. From boot camp.
>
> – Twenty-five-year-old male veteran, one year after leaving the Marine Corps

For some veterans, the commitment to the military and its values endures after they leave. That commitment, and the ideal of a reciprocal relationship between the institution and its personnel, suggests that the military's commitment to the contract endures, too. One veteran compared the Army to a big corporation, but he noted a major difference: corporations have no responsibility to their employees, in his view. Only the military has an ongoing responsibility to its personnel. This veteran asked me rhetorically:

> If you work for a company like IBM, will they care for you when you get out? Nobody would better take care of you than the Army.
>
> – Thirty-three-year-old male veteran, two years after leaving the Army

The Army—and the other branches of the military—do "take care" of some veterans in some ways, including financially. However, to understand most veterans' post-military lives and their engagement with the VA, deciphering whether or in what ways the Army takes care of anyone after they get out is not the most relevant project. In practice, the VA "takes care" of most ex-service members who are eligible for such care. After military service ends, the specific branch of the military to which veterans feel connected—the Army, the Navy, the Marine Corps—dissolves into "the government." Perhaps this is a distinction that doesn't matter for veterans—maybe to them, it's all "the government." But if the military and the VA are not synonymously "the government" to veterans, and the VA is fulfilling the military's end of the contract, then the

ideal of the reciprocal relationships necessarily collapses in the moment of the bait-and-switch when the state's responsibility is distributed between the two agencies.

The military's promises of unifying purpose, transparency, and reciprocity are ideals—fantasies—and veterans also described moments when their idealized visions of the military were proven false. One particularly clear example came from a veteran named Robbie Navarro, who had been in the Marines. He described a mandatory post-deployment health screening that felt, to him, like an enraging betrayal. Upon returning from a deployment to Afghanistan, Robbie and his unit had been surveyed about their mental health. He recounted a scene of Marines casually comparing notes on how they had answered the compulsory questionnaire that screened for post-traumatic stress disorder (PTSD).

Laughing, Robbie remembered, "We were all standing around smoking and joking afterward, and we were talking about, you know, 'Did you answer their questions?' And the majority of us were like, 'No! I left it blank!'"

They learned, however, that some of them men had not left the form blank. Instead, they answered honestly to questions about their symptoms. The group of Marines thought that may have been a bad idea. As Robbie tells the story, they were right to be worried. When the officer who had administered the questionnaire came back five weeks later, he said, "She had a list."

Serious now, he said, "And I remember all the guys that said that they had been honest on that survey—all of them were on her list."

I asked, "What was the list for?"

"They were being medically discharged. It was the most disgusting feeling ever. And I remember all of us just being in a rage. That survey—they promised us [it] would not come back

to us. It was so disgusting. So, that was our lesson, you know? When it comes to PTSD, if you talk, you're gonna find yourself kicked out. The sad thing is that that was the lesson."

I thought that an equally plausible way to interpret this "lesson" was that the Marine Corps acted responsibly by relieving service members of the obligation to continue preforming a job by which they had been traumatized. But I gathered that was not what Robbie intended for me to take away from the story. It seemed that what caused him to feel disgust with the Marine Corps was the sense of betrayal produced by the organization backing out of its end of the deal.

I asked Robbie, "So, it's like they want to be involved in all of the parts of your life until something goes wrong and you can't perform anymore?"

"Exactly!" he said. "Exactly. Then you're out. Get the hell out."

Of course, it is completely unclear why some members of the unit were on the officer's list, what happened to them, and why. But Robbie believed that his friends were medically discharged based on the survey alone, and this belief provoked in him a feeling of betrayal—his trust (in the survey? The psychiatrist? The Marine Corps?) had been betrayed. The "lesson" he learned was that the Marine Corps would require individual Marines to do something, and then punish them for doing it by unilaterally backing out of its contract with them. For him, that was an enraging, disgusting feeling.

Robbie's story is an example of an exception to the contractual relationship. When service members are injured, a shift occurs. This is an exception that MacLeish describes as "the threat of individuation" (MacLeish 2013, 114). Soldiers' jobs are to fill slots and to be interchangeable. As the veteran quoted above said, they are trained to be "not a person, but a unit—a cog in the machine." If they are hurt, they can no longer fill that role and their individuality becomes a threat to the operation of the larger machine. Injuries transform service

members into individuals, MacLeish writes, “not in the liberal sense, suddenly coming into positive possession of autonomy and individual identity, but instead in a negative sense, as an exception, a bodily unit with nonstandard and undesirable properties, mired in feeling rather than coolly detached from it” (MacLeish 2013, 115). Echoing the observations of the veterans I interviewed, and Smedley Butler’s 1934 observation, a soldier told MacLeish that “the Army is very good at taking care of large numbers of people, but when someone becomes sick or injured, they become an individual and the Army is not good at taking care of individuals” (MacLeish 2013, 114).

Conclusion

The veterans who participated in this research were using the services at the Western VA while transitioning from lives in the military to lives as civilians. Key elements of this transition included loss of a stable job at which they were competent, and membership in a community surrounded by people among whom they spent nearly all their time. Understanding veterans’ “transitions” from a demedicalized perspective delivers a more nuanced picture of veterans’ post-military experiences that does not rely on trauma as its central organizing trope.

While it is useful to move away from medicalized and trauma-centric models because they reify certain explanations for distress at the expense of others, the idea of “transition” is also something to be cautious about. For one thing, the idea of “transition” seems easily reduced to a checklist or made to appear as a specific homogenous problem that can be fixed with a well-aimed intervention. For instance, the military has for years administered “transition assistance programs” in which departing service members listen to a series of lectures about family life, employment, and accessing their VA benefits. Along the same lines, “transition” is easily

medicalized, particularly since the VA has the capacity to work outside of specifically biomedical lines. For instance, the Western VA had a dedicated "Transition and Care Management Team" in the hospital, itself. As such, "transition" becomes as susceptible to depoliticization as any other medicalized category (Zola 1978). The term "transition" is vague and it fails to name any specific problem. It fails to point to any people, organizations, or policies who might be held accountable for having caused these intersecting problems, and it risks blaming individual veterans for failing to adequately "adjust" to their post-military civilian lives. Policies and programs organized around the problems of "transition" essentially support service members as they go through an individual process of resuming civilian life, rather than altering underlying conditions that affect all service members (such as the military's continual need for more troops to fight ongoing wars, or political and ideological motivations for legislators to explicitly or implicitly authorize war) and the country as a whole (such as funding for higher education). In recent wars, for instance, service members' experience of adjusting to post-war civilian life happened amidst the larger backdrop of the country's economic recession. 2008 was the year in which the highest number of US military personnel deployed overseas at once. By the time those service members returned to the United States and left the military, the recession was in full force.

As a partial corrective to the depoliticization that occurs with the idea of "transition," I have suggested here that veterans' descriptions of leaving the military shed light on features of American institutions. The moral and political rhetoric that surrounds the VA is inextricable from the rhetoric of service, patriotism, and debt that surrounds the military. In any VA in the country, you will find an iteration of the phrase "Serving Those Who Serve," suggesting that clinicians and staff who work at the VA are repaying a debt owed by civilians to former service

members. Likewise, the contemporary VA is the present iteration of a centuries-old distinction between public assistance and veterans' benefits, which are explicitly entitlements earned through military service. Symbolically, the military and the VA are linked, but to understand the VA's institutional objectives and the mechanisms in place for achieving those objectives we need to disentangle the VA from the military. Veterans' narratives provide a way of doing that.

When people stop being service members and become veterans, their relationship with the federal government changes. People who once felt as if they were *participants* in something larger than themselves become recipients—and subjects—of federal attention in new ways that do not always make sense to them. Veterans have no reason to feel involved in the VA in the ways they felt involved in the military, and yet it often seems as if the VA is expected to exercise as much control over veterans' lives as the military once did, replacing the military as a structuring force in veterans' lives. However, the VA sits in an institutional middle-ground in that it has a mandate (and the capacity) to function as more than a hospital or a clinic, but it provides none of the features of the military that veterans idealized and say that they miss. In other words, from veterans' perspectives, the VA is a poor substitute for the military.

Politically and practically, however, when the VA seeks to study, treat, and track combat-related injuries and illnesses (as it does with mild TBI) the VA seems to have stepped into the place of the military, in a sense. I am not arguing that the VA should be exempt from the scrutiny it receives, nor that its reputation for incompetence and inefficiency is necessarily undeserved (although it is too simplistic). However, to blame the VA for veterans' post-military medical, social, and economic needs is to erroneously allow the blame to follow the *veterans* as they move between these two institutions in a way that leaves the military free of blame, making it seem as if the VA is responsible for having *caused* these problems. Furthermore, on a less

abstract level, the incongruity between the scope of the VA's moral responsibility for veterans and its power to control those veterans produces odd dynamics within the institution. As I show in the following chapters, veterans experience a sense of being summoned to VA medical centers without clear understandings of why or by whom, and VA clinicians' attention seems directed at moving veterans around and accounting for them.

When we see veterans' experiences only through the frame of medical diagnosis, it obscures any effort to understand their relationship to the government, which makes it challenging to understand their relationship with the VA. As I will describe in the next chapter, veterans are pulled into the VA, but their relationship with the VA can be confusing and characterized by a vague sense that they are obligated to be there, without the mutuality they experienced in the military.

CHAPTER 3. TARGETING MILD TBI

> In a rather ironic way, it is within the very societies whose dominant ideology held sacred the individual freedom to follow one's own way of life that the singularity of such a route soon ends up being automatically signaled as suspicious.
>
> Chamayou 2014, sec. 12

> It is VHA policy that all OEF and OIF veterans receiving medical care, within VHA, must be screened for possible TBI.
>
> VHA Directive 2007-013

When the TBI Clinic at Western began in 2003, the same year the war in Iraq began, it was not a physical clinic like the one I studied. The earliest iteration of the "clinic" was a team of doctors whose primary appointments were in other medical departments; they came together to address individual veterans' TBI-related needs as they arose. Mara Danzig was one of the three original clinicians working in the clinic. Mara was in her mid-fifties; a tall, graceful woman with a calming presence. She once told me that she read poetry in the morning before arriving at the VA for work. As a neuropsychologist, Mara was among the doctors who conducted neuropsychological evaluations. These are hours-long standardized tests, administered verbally,

that evaluate brain function. Doctors like Mara evaluate veterans' intelligence, executive functions (planning ability, abstraction), attention, memory, language, mood, and emotion. Though these elaborate assessments were not required for all of the TBI Clinic's patients, Mara was involved in most veterans' care as a member of interdisciplinary team. In the early days of the TBI Clinic, Mara remembered, there were many fewer veterans:

> It started out very slowly. Patients kind of dribbled in. That was before there was a lot of structure to the TBI program, so I was just seeing patients here and there.

Mara worked like this for a few years, providing general neuropsychological assessment and care to different groups of veterans, and occasionally working with Elena to provide specialized care for veterans with histories of TBI and moderate-to-severe cognitive impairments. In April 2007, the VA made a policy change that transformed the TBI Clinic from a loosely-connected group of specialists into a physical clinic where any veteran who *may have had* a combat-related concussion could receive a thorough assessment and coordinated care. This shift was prompted by a new screening protocol that was administered to all OEF/OIF veterans who were new to the VA. The screening protocol was called the TBI Clinical Reminder and its implementation was, in Elena's words, the "big change" in the clinic:

> The big change was in 2007. They rolled out the TBI clinical reminder. So, we started seeing the patients referred to us through these reminders. And our numbers quadrupled immediately.

The change provoked by the new screening protocol was significant for at least two reasons: it drastically increased the clinic's workload, and it changed the task. From 2003 until 2007, Mara and Elena worked with veterans whose pronounced cognitive impairments were clearly the result

of moderate-to-severe TBI. From Elena's perspective, the 2007 screening protocol shifted the clinic's focus to the amorphous problem of "community reintegration." She said:

> It really changed the focus of the clinics. Rather than taking people who had been severely wounded, it was a community reintegration process for veterans coming back to their home area, looking at their lifetime medical needs. Now we were assessing whether somebody had a concussion *at some point during their service*, and whether they're having any current symptoms, and how we're going to help them with that. So, it was a very different focus.

As Elena and Mara's descriptions demonstrate, screening all OEF/OIF veterans for exposure to mild TBI changed the everyday operations of the clinic. When the VA began this practice, it also problematized the injury in a new way: mild TBI became something to be detected in the population of young veterans who were otherwise at large, living out in the community, independent.

In this chapter, I describe the process and effects of problematizing mild TBI as something to be detected in a population. The chapter proceeds in two stages. First, drawing on anthropology and sociological literature on medical screening, I discuss the VA's TBI screening procedure, which is a questionnaire, administered through the VA's electronic medical record (EMR) system. My analysis shows that the questionnaire is an institutional technique of movement that puts veterans in contact with clinicians who become responsible for coordinating and documenting these movements around the VA. My interviews and observations show veterans' impressions of being moved around by this screening protocol, and clinicians' reactions to how the protocol shapes their work.

In the second part of the chapter, I explore how the screening procedure disciplines VA clinicians' attention so that they notice when veterans are insufficiently "connected" to the VA. I explore clinicians' use of circuitry metaphors, and how medical center staff come to be put in this position of tracking veterans "connections" to the VA. Drawing on post-Foucauldian theories of discipline, governance, control, and tracking, I show that clinicians monitor and assess veterans' movements. I theorize veterans' movements—and the VA's concern with them—within the practices of power Grégoire Chamayou describes as targeting (2014). Veterans' medical records function as portraits—not of their bodies, but of their movements. The portraits are renderings of the dynamic form of a body's trajectory, and they allow clinicians to direct their attention at gaps, inconsistencies, and interruptions in veterans' engagement with the VA.

SCREENING GENERATES MOVEMENT

Institutions are often involved in minimizing movement. Even spatially diffuse institutions, such as community mental health services, endeavor to keep people in place—consistently housed, consistently medicated, and under the supervision of a case manager acting as an "agent of stability" (Browdin 2014, 66). However, institutions like prisons and hospitals that generally fix people in space are nonetheless involved in moving people and things. For instance, Rhodes (1991) shows that clinical work in a locked hospital psychiatric ward revolves around moving patients out of the ward—or "emptying beds." As part of a public hospital, the unit was obliged to accept more patients than it had room for, and therefore clinicians became managers of movement (Rhodes 1991, 32). In a different setting, the maximum security prison, the process of moving prisoners is part of categorizing them (Rhodes 2004). Those who will live

as part of the "general population" are separated from those sent to live in mental health units by mental health workers who interview each new inmate as they are processed into the system: "the task here is to snag out of the flow of passing prisoners those few who stand out as unable to manage in the group" (Rhodes 2004, 102).

Sorting people requires tools with which to do it. In the prison, the tools include the questionnaire and the personnel. Rhodes quotes a prison officer as saying, "We are just like the guys who work on loading docks—we're trying to *move* stuff" (Rhodes 2004, 101, italics in original); prison mental health workers use a simple questionnaire to complete their task of isolating new inmates with severe mental health concerns. Other tools for sorting and moving people include ID cards, diagnostic categories, expertise, screening procedures, and other technologies and techniques for the conducting of conduct (Miller and Rose 2008). For instance, moving someone from the community into a psychiatric hospital requires case workers to use a certain set of tools: paperwork, assessment forms, treatment plans, and legal documents for commitment (Brodwin 2013, 5). As Brodwin writes, "[frontline community psychiatry staff] must manage the crisis that just blew up in their face or carefully move a given case to the next step in an intricate dance of paperwork and phone calls" (Browdin 2013, 4).

One key technology of movement—central to the practice of medicine, and central to my argument in this chapter—is the medical chart. Like the institutions in which they are produced, medical charts provoke both fixity and movement. As a technology of fixity, the chart "constitutes what Foucault calls the dossier, an essential feature of the disciplinary regime of the hospital, school, and prison. The chart is important to the disciplining of individuals because it makes them uniformly visible, organizing them in terms of standardized norms" (Rhodes 1991, 110). Medical charts compile information that comes from examining a patient, and

"examination (whether in school or a hospital) […] 'places individuals in a field of surveillance [that] also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them.'" (Rhodes 1991, 110 citing Foucault 1977, 188). As I will show in this chapter, one of the ways that VA medical charts, specifically, work to capture and fix veterans in an institutional network is by provoking their movement.

Veterans' movement around the VA is achieved with another key technology—the medical screen. Broadly, medical screening identifies diseases before they manifest symptoms (Morabia and Zhang 2004), and is distinct from medical diagnosis. Population-based screening is suggested to everyone in an identified target population and "involves the purposeful application of tests to an asymptomatic population in order to classify people into those who are *unlikely* to have or develop a disease and those who are *likely* to have or develop a disease" (Armstrong and Eborall 2012, 162, italics in original). One of the oldest screening programs in the United States is the Army's history of administering psychological tests, which dates to 1917; other longstanding screenings include the Wasserman test for syphilis, and urine and blood glucose tests for diabetes (Morabia and Zhang 2004). Contemporary Western health care systems preform systematic population screens for cervical cancer, breast cancer, bowel/colorectal cancer, abdominal aortic aneurism, diabetic retinopathy, and multiple antenatal and newborn screenings (Armstrong and Eborall 2012, 162). Population-based medical screening brings together theories of surveillance, responsibilization, risk, and uncertainty (Armstrong and Eborall 2012); Rose notes that in the criminal justice context, screenings produce a conjuncture of two related senses of risk—identifying "risky individuals" before they harm others, and identifying "individuals at risk," who may be susceptible to some future condition (Rose 2010, 80).

The TBI Clinical Reminder that I discuss in this chapter is an example of a population-based screening tool, but VA clinicians are not screening for the presence of an underlying disease or genetic predisposition that has yet to manifest symptoms. Rather, the TBI screen detects past events, and thus, it is somewhat unique in the larger context of medical screening.

A HUGE FISHING NET

The TBI Clinical Reminder and Screening Tool that the VA implemented in 2007 consists of four questions, asked to veterans by any VA clinician they happen to meet in the health care system:

1. During any of your OEF/OIF deployment(s) did you experience any of the following?

    Blast or Explosion – IED (improvised explosive device), RPG (rocket propelled grenade); Land Mine, Grenade, etc.; Vehicular accident/crash (any vehicle, including aircraft); Fragment wound or bullet wound above the shoulders; Fall

2. Did you have any of these IMMEDIATELY afterwards?

    Losing consciousness/"knocked out"; Being dazed, confused or "seeing stars"; Not remembering the event; Concussion; Head injury

3. Did any of the following problems begin or get worse afterwards?

    Memory problems or lapses; Balance problems or Dizziness; Sensitivity to bright light; Irritability; Headaches; Sleep problems

4. In the past week, have you had any of these symptoms?

> Memory problems or lapses; Balance problems or dizziness; Sensitivity to bright light; Irritability; Headaches; Sleep (VHA Directive 1184, Attachment A).

As per the VA's policy (VHA Directive 2007-013), any OEF/OIF veteran enrolled in VA health care, anywhere in the country, is to be asked these questions. The TBI screen is administered in person, read to the veteran by a clinician, who enters the veteran's answers in their medical chart. From 2007 through 2017, VA clinicians nationwide asked these four questions to over one million OEF/OIF veterans, which is about 73% of the OEF/OIF population enrolled at the VA (US Department of Veterans Affairs 2015). Of the veterans screened throughout the country between 2007 and 2013, over one hundred thousand (108,942) were funneled to the TBI Clinics for further evaluation (US Department of Veterans Affairs 2015, 6). This was the "big change" that Elena described, when the number of veterans coming to the clinic "quadrupled." [21]

In this chapter and the next, I discuss the consequences of this four-question TBI screen. To do so, I turn to a metaphor that a neurologist in the TBI Clinic at Western used to describe it. He was a neurologist active in the field when the VA began screening for TBI, and although he was not yet working the TBI Clinic in 2007, he remembered having the sense that the VA was responding to an emerging problem. He said:

> I feel like they really started realizing, "Oh, shit, we'd better start paying attention to this."

[21] Not all veterans referred to TBI Clinics for further evaluation are determined to have sustained mild TBI. From 2007 through 2013, about sixty percent of the veterans funneled to the TBI Clinics were confirmed as having had a deployment-related TBI (US Department of Veterans Affairs 2015, 6).

He also had the impression that the circumstances of creating the TBI screen were perhaps not ideal, from a medical perspective. “I think the system got hastily put together,” he said.

> I think the DoD and the VA, driven largely by Congress—and in some ways by public perception—wanted to pay attention to TBI. They may not have figured out the best way to pay attention, or find out who needed the attention and who didn’t.

The neuropsychologist evocatively described the TBI clinical reminder itself as a “net”:

> [The VA is] basically throwing out a huge fishing net. We get everything when we ask, “Have you ever had any memory problems? Have you ever been hit on your head?’”

This doctor was not alone in conceptualizing the TBI clinical reminder as a “huge fishing net.” Other VA researchers have published similar observations in research about the effectiveness of the screen, itself:

> The [VA’s] goal was to develop an instrument to screen OEF/OIF returnees presenting to the VA for health care in an effort to identify those who may have sustained deployment-related TBI and were currently experiencing symptoms that could be related to the TBI. A deliberate choice was made to *cast a wide net* […] (Donnelly et al. 2011, 442, italics added).

Because of the “wide net” cast by the TBI Clinical Reminder, veterans with less severe injuries began to be referred to the specialized TBI Clinic. This was the intended effect of the VA’s effort to make sure that anyone who *may* have had a concussion received a full evaluation by a VA doctor who was qualified to assess for mild TBI. The metaphorical fishing net of the TBI Clinical Reminder is woven of the electronic boxes that pop up when any clinician at the

Western VA opens the medical record of an OEF/OIF veteran who has not already been screened. This means that if an OEF/OIF veteran goes to Western to see an ophthalmologist, or a social worker, or a physical therapist, these non-specialist clinicians will be prompted to complete the TBI screen. If the veteran answers affirmatively when asked, the hospital information system prompts the physician to refer the veteran to Elena's specialized team at the TBI Clinic.

To summarize, the TBI Clinical Reminder and Screening Tool is a mechanism by which veterans with possible histories of combat-related mild TBI are flagged within a population and, I argue below, it is also what instigates clinicians' scanning and tracking of veterans' movements.

CLINICAL RELENTLESSNESS

The VA is an Accountable Care Organization (ACO), which is a "[structure] dedicated to quality and efficiency with the mission and the authority to impose practice, reporting, and compensation standards (including penalties and rewards) across a group of physicians on behalf of a patient population" (Burke 2011, 875). Put in plain language, "when an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program" (Centers for Medicare & Medicaid Services 2017). Key features of the VA as an Accountable Care Organization are that it serves a defined population (VA-eligible veterans) and that the VA has the authority to impose practice standards for its staff (the TBI Clinical Reminder, for instance) in service of its larger goal of improving care while reducing cost. The VA's status as an ACO is the foundation of the TBI screening procedure because in an ACO, *population-based* screening is financially advantageous to the

health care system and easily enforced among its staff. In the VA, the success of the "net" of the TBI screening procedure relies on two things: first, the VA's electronic medical record, the Computerized Patient Record System (CPRS), which dates to system-wide reforms of the 1970s, and second, VA clinicians' federally-mandated relentlessness.

In the 1970s, the need to coordinate care between medical centers prompted VA doctors to develop an early version of an electronic medical record. It was one of the first of its kind. The necessity of an electronic medical record was particularly apparent to VA doctors for three reasons that were specific to the VA and its patient population: first, in the 1970s, World War II veterans were aging and they needed treatment for complicated, chronic conditions. Many of those conditions—like diabetes, for instance—required daily monitoring (both by the patient and by the clinicians), and effective coordination between nurses, radiologists, lab technicians, pharmacists, and therapists. Second, this aging population was taking multiple medications and was therefore vulnerable to medical errors like drug interactions. Third, caring for these patients was expensive, so doctors and administrators "had an exceptional need for data about which of these treatments worked better than others" (Longman 2007, 31). Today, the VA uses a version of the very hospital information system that was developed then.

The computer program originated as a revolt by VA doctors against the VA's administration, a story best told by journalist Philip Longman (2007).[22] Individual doctors secretly wrote the software as an alternative to the poorly-designed software systems forced upon them by the VA's central Office of Data Management and Telecommunications. In developing their own software, the doctor-programmers skirted the seventeen-step bureaucratic approval

[22] The group of VA programmers preserved this history on their own website (http://www.hardhats.org/index.html), which is updated to this day with news about developments in the VA's VistA software, including the results of a 2014 survey of 18,575 physicians who named the VA's CPRS system as their most preferred (Medscape EHR Report 2014, by Leslie Kane and Neil Chesanow, July 15, 2014).

process for new software, and they continued to use the software to treat veterans despite VA leadership's efforts to stop them.

In 1981, the doctors' innovation in computerized medical record-keeping broke to the press. By then, the doctors were writing and sharing programs to print pharmacy labels, analyze psychological testing results, maintain tumor registries, and preform nutrient analysis for the treatment of diabetics—all without permission from the VA administration.

The disagreement between the doctors and the administrators persisted until the VA's Chief Medical Director at the time, Dr. Donald L. Curtis, visited the neighboring Washington DC VA (six miles from his office at the VA's Central Office) to see what was happening. The Medical Director acknowledged that the unauthorized use of self-made software for patient care constituted "obvious insubordination," but applauded the doctors' effort anyway (Longman 2007, 29). The administration stopped blocking the doctors' work, but did not officially adopt their programs for use across the country until a decade later. The doctors ultimately prevailed because their programs were to the VA's advantage. Longman writes:

> There was a pressing institutional need to coordinate record keeping among the many different VA hospitals and clinics a veteran might use over his or her lifetime. And, crucially, it meant that any improvement to the quality of care the VA could achieve though its investment in information systems would rebound to its own long-term advantage (Longman 2007, 31).

During the push to make the VA an efficient and cost-effective Accountable Care Organization between 1997 and 1999, the computerized health information management system that the rogue VA doctors had developed in the 1970s was implemented nationwide as the Computerized Patient Record System (CPRS) (Kizer and Dudley 2009, 322).

The data generated by today's VA clinicians' use of this hospital information system is stored in a data warehouse in Austin, Texas. The VA stores two billion text notes, written about twenty million unique veterans. It also has data about 1.6 billion outpatient encounters, 2.3 billion recorded vital signs, and 5.6 billion lab test results.[23] This data is used by doctors, administrators, and researchers for all kinds of purposes. For example, the information system makes it possible to pinpoint certain individuals within the VA's larger population of users. In 2005, there was a recall of an arthritis medication, and the VA was able to immediately identify and contact all of the patients taking the medication (Longman 2007, 39). Likewise, when there has been a shortage of flu vaccines, the VA has been able to use its hospital information system and distribute its supply according to veterans' age and health status (Longman 2007).

The second part of operating the "net" is clinicians' adherence to the VA's very specific required practices regarding TBI screening and evaluation. CPRS tracks information related to veterans' health, but it also manages clinicians' behavior, as when the system is used to implement clinical screening procedures like the TBI Clinical Reminder I describe here. To extend the metaphor of the fishing net, the clinicians who worked in the TBI Clinic did not cast the net themselves. Rather, the net was operated by their colleagues in other clinics—primary care doctors, nurses, social workers—the people who would be the first points of contact for veterans who enrolled in the VA. Certain veterans' records are "flagged" to indicate their membership in a population (like OEF/OIF Combat Veterans). When a veteran's record is "flagged," a clinician who opens the electronic CPRS file will be prompted to take some action—in this case, the clinician would be prompted to administer the four-question screen for TBI exposure.

[23] MITRE Corporation Assessment H: Health Information Technology, September 1, 2015. Accessible at: www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf

Doctors in the TBI Clinic—Elena, Mara, and colleagues—entered the scene only after veterans had been screened for exposure to TBI. However, the larger effort to offer veterans specialized TBI evaluations governed *all* clinicians' behavior. Specifically, it required clinicians in the TBI Clinic to make and document many attempts to reach a veteran who had screened positive for possible exposure to TBI, and expressed interest in further evaluation. As per the 2007 policy:

> The identified service [the TBI Clinic] initiates contact with the referred patient within 1 week […]. If initial contact effort is unsuccessful, follow-up efforts must include at least two telephone calls [one] week apart followed by a certified letter. These efforts and any refusals by patients to participate in the recommended evaluation must be documented in the progress notes of the patient's health record (VHA Directive 2007-013).

Clinicians in the TBI Clinic took these rules and timeframes seriously, but in practice, they make little sense. It was a challenge to get in touch with busy veterans—parents to young children, who were working and taking college classes, or veterans marginally housed and managing other demands on their time. And when the clinic staff did establish contact with veterans, appointments were often missed and rescheduled several times, which disrupts the timeline imaged by VA administrators who are not practicing clinicians. Thus, in the clinicians' words, they had to be "relentless." During my research, I was surprised that many veterans would show up to appointments without knowing why they were there. (Below, I offer an ethnographic example of such a situation.) What would make a person show up to a medical appointment without knowing why, and without a need or desire for some kind of care or recognition? I once

asked one of the VA clinicians this question. The doctor smiled, and responded, “We’re relentless in this clinic.”

Indeed, evidence of their relentlessness was etched in veterans’ medical records—Elena’s team of clinicians was required to make three attempts to contact any veteran who wanted to have the specialized evaluation. These phone calls were made and documented by Elena, or by the clinic’s nurse, or by its two dedicated social workers. Elena explained:

> Congress, [the VA’s] Central Office, the Office of the Inspector General—they are all watching us to make sure that we are seeing these patients in a timely manner. They want us to get them in for their evaluation within thirty days of their screen.

The procedure made more sense from a Congressional perspective than from a medical one.

VETERANS’ VIEWS FROM INSIDE THE NET

Anthropologists describe clinical situations that trouble the boundaries between care and control, in which people are forced to be patients. Two extreme examples are Hejtmanek’s research (2015) on the subjective transformations of young men confined in a mental institution, and Waldram’s (2012) ethnography of a therapeutic prison unit where sexual offenders are treated. VA treatment is not mandatory, but the TBI screening procedure nonetheless upends the expected clinical situation in which a patient seeks the opinion of a doctor for some specific problem. The TBI screen pulls veterans into the clinic. Once veterans are there, the effects of the screening procedure seep into the clinical encounter itself. Instead of veterans actively seeking advice or medical interventions, veterans often arrive at the TBI Clinic with a vague sense of having been summoned. In this section, I use ethnographic examples to show how the TBI

Clinical Reminder affects veterans. For some veterans, being screened for past TBI and referred to the TBI Clinic felt like being passed around the facility like a baton, or just "going through the motions." Moving between different VA clinics felt rote and predictable, and in fact, that is precisely what a screening protocol is meant to do.

Below, I recount the clinic visit of a veteran, Nathaniel Marquez. Like many veterans whose evaluations I observed, Nathaniel showed up at the TBI Clinic with very little knowledge of why he was there or what to expect. Nathaniel was injured in 2012 when he was driving an armored truck in a convoy on a narrow mountain road in Afghanistan. A bomb was detonated under the vehicle in front of his. Nathaniel was temporarily blinded by the explosion but not knocked unconscious. In 2014, his responses to the four TBI-related questions he was asked at the Western VA suggested that he should be evaluated further, which was how he ended up in the TBI Clinic.

Just before nine-o'clock, Dr. John Moy walked out of the exam room and toward the waiting area. I trailed behind him. The waiting room was open, sunlit through huge front windows. In other parts of the medical center, there were usually brochures laying around on all available surfaces, but not in the TBI Clinic, where the area was tidy and modern-looking. A morning talk show was playing on the TV, under which stood a child-sized, brightly-painted wooden table surrounded by chairs, books, and toy trucks. I rarely witnessed a patient bring his children with him to an appointment, but the presence of these items suggested something about how the patient population is imagined.

Sitting in the waiting area, alone except for the two clerks, Nathaniel Marquez looked toward us when John opened the door and said, "Mr. Marquez? I'm Dr. Moy. This is Anna, our anthropologist." Smiling, John held the door open and gestured inside, "Come on in."

Exam room in the TBI Clinic. Photograph by the author.

In the exam room, John sat in the wheeled desk chair, and gestured for Nathaniel to sit in the chair to his right. A bulletin board hung above the computer monitor, practically empty except for the royal blue ICD-9 chart for coding traumatic brain injuries. The maroon vinyl chair in which Nathaniel sat was the boldest color in the room. The walls, filing cabinets, and furniture bled into each other in a pallet of muted tan, grey, maroon, and sage green. The natural light from the large window over the exam table was also muted by a frosted window pane—necessary, because the one-story clinic was situated along a busy walkway that led from the expansive main parking lot to the hospital. Over the grey bulletin board hung a large rectangular digital clock, also grey, set to 24-hour time. The room was completely free of posters, pens, and

pads of paper bearing pharmaceutical company logos—the VA negotiates its drug formulary at the national level and no advertising from corporations is allowed.

The computer screen separated the two men. John typed, sitting straight and tall, with both feet on the waxed wooden floor. Looking at CPRS, he confirmed Nathaniel's current phone number and address. Nathaniel's neighborhood was about twenty miles south of the VA medical center; in the morning traffic, it would have taken close to an hour for Nathaniel to drive those twenty miles. Since he could expect to be at the TBI Clinic for about ninety minutes, Nathaniel likely had to take the morning off from his part-time job at AutoZone, or schedule the appointment around his school and child-care commitments—Nathaniel was a married and the father of a nine-year old and a two-year old, and he was in school for electrical engineering.

John typed and talked, asking Nathaniel about his two deployments with the Army, and his symptoms. Nathaniel told John he had headaches, and insomnia, and that he frequently forgot things that his wife told him.

John asked, "How much do you think the symptoms are affecting your life? Is the effect mild… moderate… severe?"

"I would say moderate," Nathaniel answered. "Severe is such a big word."

"And how are the symptoms affecting your life?" John asked.

"I get cranky. So, it does have an effect at home. I wake up with a headache, and so getting the kids dressed is hard."

John read the next question verbatim from the clinical questionnaire he was using, "Since your deployment, have your symptoms gotten better or worse?"

"Oh, worse," Nathaniel answered. "I wasn't affected right off the bat."

There was a moment of silence, while the doctor paused to read something in Nathaniel's medical record.

Breaking the silence, Nathaniel asked the doctor, "So, what exactly is this appointment for?"

"This is the TBI Clinic," John said. "If there is a positive screen, our goal is to see what tools we can give you to deal with the root cause problems. My goal is to elicit a good history and give you all the resources you need."

Nathaniel's question marked a departure from the predictable rhythm of medical care in which a patient perceives a problem and seeks a doctor's assistance in understanding or solving the problem. We expect a doctor to ask us what has brought us to the clinic, not the patient to ask the doctor what has brought them to the clinic. But Nathaniel's presence in the clinic was the intended outcome of the clinicians' relentlessness.

After his appointment ended, I talked with Nathaniel in the parking lot. He told me that he was not fully satisfied, and that the reason he had come to the TBI Clinic was that another doctor was not doing a sufficient job helping him with his insomnia. What he had experienced with John in the TBI Clinic felt perfunctory. John was nice, Nathaniel said, but he thought the evaluation would be more specific to finding out what had happened during his time in the military. Nathaniel felt of his appointment that, "it seemed like just passing the baton." "Passing the baton" implies being shuffled around and dismissed. Indeed, Nathaniel may have felt passed around because that is precisely what the screening procedure is designed to do.

Another veteran described his experience at Western as a rote and predictable procession along a well-defined pathway: "It's kind of like a connect-the-dots type of deal." He described moving between clinicians who told him that he needed this or that screen or evaluation. He said,

"It's always brought up— 'Well, you need this. You need that'." I asked him what he expected from his appointment at the TBI Clinic, and he told me that he really had no expectations. He said:

> I feel like I was in such autopilot mode, you know what I mean? I have an alarm go off on my phone, I look at it, and it says be at [the TBI Clinic] in fifteen minutes. Get in the truck drive over to [the Clinic]. Sit there and answer questions.

Although these veterans felt confused by how they arrived at the TBI Clinic, both were guided there by a specific set of procedures in place at the Western VA (and at all other VA medical centers in the country).

For some veterans, receiving phone calls from VA staff seemed to produce a vague sense of being summoned to the medical center. For instance, Dr. John Moy asked one veteran, "Do you know why you're here?" The veteran responded, "I said I had a TBI. Well, I suspected I had a TBI. I don't know. And they called me."

I didn't interrupt John's exam to ask this veteran what he meant when he said "they," but I think that the undifferentiated "they" was, in its vagueness, appropriately descriptive of how veterans experienced this kind of summoning—perhaps what it felt like to be caught in the fishing net thrown by the VA. Perhaps being summoned to the VA and to the TBI Clinic by an undifferentiated "they" recalls something of life in the military, where one learns to do as they are told. Maybe these veterans also don't totally understand the difference or at least the relationship between the military and the VA. Questioning the identity and authority of "they" is anathema to the military project, and according to some veterans' accounts of transitioning out of

the military, there is something liberating about relinquishing the responsibility of everyday decision-making to someone giving orders.

Paula da Rosa was one of the people responsible for relentlessly reminding veterans to schedule and then attend their VA appointments. Before she started working at the TBI Clinic, Paula had worked on an inpatient unit at Western, across the campus in the six-story hospital building. She said that working in an outpatient setting like the TBI Clinic was challenging in a different way because the staff has less control over the factors shaping the social and medical issues they are tasked with addressing. On an inpatient unit, she said, the staff just did everything for the patients. Furthermore, she explained, the veterans she cared for as inpatients were so sick that the only thing any of the staff focused on were their medical issues. In some ways, Paula said, it was easier to fix things medically than it is to deal with the other, social dimensions of veterans' lives as she did in the TBI Clinic. Of the TBI Clinic, she said, "Here, it's up to them. They're living in the community, integrated, back at home. A lot of the issues here are social issues. It's all integrated."

Implicit in Paula's description was the idea that VA staff is limited in what they can do to help veterans when veterans are "out there," at large in the world. The fact that VA clinicians could only help veterans who were actually using the VA prompted a particular kind of noticing from VA clinicians.

For instance, social workers consistently read veterans' medical records for evidence that veterans were either using VA services, or missing appointments. This was a way to assess the depth and breadth of someone's participation in VA care. In an interview, one social worker narrated what she saw when she looked at a veteran's chart:

> Alright, I know he's receiving his speech therapy. He's going to neuropsych[ology]. He's going here, you know, or she's going there, and receiving mental health services. If I see that they haven't been going to their appointments, I'll give them a call. Just kind of find out.

When she got veterans on the phone or reached their voicemail she said, "Oh, I'm just noticing that you missed your follow-up and wanted to know if you wanted to reschedule. Feel free to give me a call."

I asked, "What kinds of responses do you get to those calls?"

She said:

> They've been pretty positive. They'll call me back, but [say] you know what, I'm working right now and I can't get away. I'm like, 'Okay, no problem, we'll follow up in a month and just see where you're at. Maybe you can come in.'

Nurses' and social workers' phone calls to veterans demonstrated a dimension of health care at the Western VA that seemed to be about bringing veterans into the institution. Much of this relentlessness was required by national legislation, and some of the phone calls that a veteran might receive from the undifferentiated "them" at the VA were simply—and humanely—a way that VA clinicians tried to help veterans. But ultimately, clinicians cannot force a veteran to seek health care.

Prompting veterans to come to the VA had consequences that made clinicians' work more difficult, in some cases. For instance, a neuropsychologist lamented that she sometimes felt frustrated by the VA when it seemed like veterans were participating for reasons other than wanting to get better. She compared the VA to courts and prisons, where people are pushed into treatment by an institution that controls them.

> [Patients with court mandated treatment] may very well need treatment, but the motivation isn't coming from them. And sometimes there's hints of that here, where it just feels like patients are just sort of going through the motions. They're not looking for the type of assistance or help or expertise that I was trained in. It can be disheartening. It can be hard.

As an example of veterans "going through the motions," the doctor told me that some veterans called her and said, "I'm supposed to make an appointment." To these veterans, she would say, "No, at this point, it's voluntary and I hope you're getting something out of this." They would respond, "Somebody told me I needed to do this." The doctor continued,

> We're talking about thirty-five-year-old men. Nobody's making you do anything! Again, if we were in a different medical setting, [it would be] like people, of their own volition, [saying] "I have a problem and I'm coming here and you're my doctor and you are accountable to me."

Just as Nathaniel asked Dr. John Moy what his appointment was for, the veterans this doctor referenced were not acting as patients are supposed to act in clinical encounters. This is evidence of one of the ways in which the VA is not a hospital in the conventional sense, characterized as it is by clinicians' attention being directed not at veterans' bodies, alone, but at the quality of their involvement with the institution. In the next section, I give another example of clinicians' tending to veterans' "connections" to the VA, and finally, I analyze these examples in the theoretical terms of control and surveillance.

THE RISKS OF BEING UNCONNECTED

At the time of my fieldwork, Robbie Navarro had been using the Western VA for about a year. As part of his participation in my research, he gave me written permission (as per my research protocol) to view and analyze his electronic medical record. In just twelve months, VA staff had put eighty-five separate entries in Robbie's chart. Although he was being treated for symptoms related to post-traumatic stress and dealing with the lingering effects of his badly-broken nose, Robbie was a thirty-year old with no disease or chronic physical health problems. He was conscientious about his health, he participated in most of the programs available to OEF/OIF veterans, and he attended the appointments that were made for him. But even so, Robbie did not visit the VA on eighty-five occasions during that year. Each of Robbie's visits was an opportunity for VA clinicians to document many different things. Every blood test, post-deployment health screening, and phone call made by a social worker became a unique note in Robbie's chart.

For example, the events surrounding Robbie's first visit to the TBI Clinic were documented in twelve notes, written by four different VA staff members. One note documented the screening protocol that brought him to the clinic; one note documented that the TBI Clinic received the results of the screen; three notes documented Robbie's phone conversations with the nurse about scheduling, and the times the nurse called to remind Robbie of his appointment. When he was finally evaluated at the TBI Clinic, more notes documented a physician's evaluation of Robbie's history and the social worker's standard assessment, which included an itemized list of the pamphlets and information sheets Robbie received, about topics such as VA's recommendations regarding advanced directives, a standard suicide risk assessment, information about the GI Bill, and so on. These notes were also evidence that the clinicians had followed the

VA's protocol for caring for Robbie—and that in those twelve months, they had solidified Robbie's connection to the VA in eighty-five different ways. In these twelve notes, the work of one nurse, two physicians, and a social worker were electronically etched into the institution's record of its relationship with Robbie.

Why such excessive documentation? Robbie's medical record was evidence of his relationship with the VA: clinicians knew how to get in touch with him, which VA clinic was closest to his home, when he was next expected at Western, and whether he was filling his prescribed medications. The record was evidence that he had been offered services, and that he had accepted those services. Because he was accounted for, Robbie did not represent a risk, and clinicians could turn their attention elsewhere—scanning other veterans' records that stood out as targets of their attention. Robbie was what the clinicians would call "plugged in."

I had heard doctors use the phrases "plugged in" and "connected" throughout my fieldwork, generally while they looked over veterans' medical records. For example, when I was observing an examination in mid-January 2014, a veteran sat silently in the chair next to the desk, while a TBI Clinic doctor reviewed his electronic medical record. With his hand, the doctor turned the wheel in the center of the computer mouse, and visually scanned the medical record on the screen, commenting that it was good thing the veteran was "plugged into mental health."

"What does 'plugged in' mean?" the veteran asked.

A good question, I thought. I had noticed that doctors used these circuitry metaphors, but I had not yet asked anyone what they meant.

"You saw someone [in mental health] in December," the doctor responded. "Didn't you?"

"No," the veteran said. "I got out in August and I've only seen the VA for the thing they sent me to for my claim."[24]

"Is mental health treatment something you want to do?"

"Yes."

It turned out that this veteran was *not* "plugged into" mental health, and the doctor made a standard referral so that the veteran could access mental health services. It was as if this scanning, checking for connections to different departments, was a standard part of care—like checking someone's blood pressure. For veterans who were unsure why they were in the TBI Clinic or who felt like someone had instructed them to show up there, checking for "connectedness" to the VA was one way the doctors could help. When VA clinicians detected gaps in a veterans' use of the appropriate VA services, they also succeeded in demonstrating a particular kind of clinical competency. Like medical students in an emergency psychiatric unit who "had to find ways of feeling capable and competent that did not depend on whether the patient shared their goals, got better, came back, did not come back, or appreciated them," doctors in the VA clinic embraced pragmatism as "care" (Rhodes 1991, 57).

When I eventually did ask the doctors explicitly about their use of these circuitry metaphors, Mara, the neuropsychologist, thought about it for a few seconds before responding. The VA, she explained, was like a "vast switchboard," a fragmented system in which veterans visit doctors and doctors "send them off to another department." If the VA was like a vast switchboard where veterans are moved from one clinic to the next, then doctors became like

[24] He meant a Compensation & Pension evaluation, an evaluation performed by a doctor; it is explicitly not treatment, but rather documentation of a medical condition for which a veteran is filing a claim to service-connected disability payments from the Veterans Benefits Administration (VBA). Although it's possible to differentiate between Compensation & Pension evaluation notes and VHA clinical notes in CPRS, they all appear in one list and it would be easy to mistake one for the other. The integration (and sometimes, the lack of integration) of the VBA and VHA caused constant confusion at the VA.

switchboard operators—they see the landscape of clinical care options in front of them, but their perspective of the "switchboard" is likely opaque to veterans. Thus, it starts to make sense that veterans might feel like batons being passed between doctors, or phone lines being "plugged in" to different slots on the board.

Mara pursued her switchboard metaphor to its logical end, and explained that VA doctors were tasked with "plugging [veterans] in, and hoping the circuit board is working." In one sense, this task entailed comparing what the medical record seems to suggest with veterans' actual experience, and correcting any malfunctioning circuits, as in the example above of the veteran who turned out to *not* be "plugged in" to "mental health," though his medical record suggested he was. In another sense, it meant making sure that other doctors in other VA clinics were available on the receiving end so that the connection could be made and the circuit completed.

For instance, when I asked Elena what it meant for veterans to be "plugged in," she said that it was important that doctors facilitate veterans' initial "connections" with the VA so that the connections were available to be reactivated as necessary in the future. She explained something like priming an engine before starting it:

> Well, I think it's that they're [veterans are] connected. The services are *available*, then. You know, if they haven't had that first appointment with primary care or mental health or whomever, sometimes that's the biggest hurdle. Once you've had that appointment, even if a year or two has gone by, you can call back up and say, "Dr. so-and-so saw me and I need to see them again."

This interpretation points to the (imagined) permanence of veterans' relationships with the VA. Making veterans "plugged in" completes the circuit and makes the services "available" indefinitely. Even if doctors imagine themselves to be "connecting" veterans to the institution of

the VA, or to some circuitry of care that it supports, it is not clear whether such circuitry even exists. Nevertheless, in this context of accountable care for a politically high-profile population, there is something meaningful about bringing veterans *to the VA*—they have been summoned, accounted for, and marked for future tracking in some way.

Scanning for malfunctioning circuits and connecting veterans to VA services, therefore, was one thing that doctors could do for veterans. Extensively-documented veterans, like Robbie, indicated a "connection" to the VA, and that was a meaningful form of care in the context of an overwhelming federal bureaucracy. The medical record is not only evidence produced by and within the institution, but evidence of the institution's presence in a veteran's life. Clinicians seemed reassured when they saw a medical record—like Robbie's—that demonstrated "connection." Surely there was administrative safety in following the protocol, but there seemed also to be a more abstract safety represented in the "connection" to the VA itself—being fixed, if momentarily, within the sight of an institution.

In a 2014 editorial in *The New England Journal of Medicine*, a VA administrator noted that there is a paradox about the VA: veterans consistently have problems gaining access to the VA (exemplified recently by the 2014 Phoenix waitlist scandal), and yet, the VA consistently performs well on standard hospital quality and patient satisfaction measures. The paradox, he suggests, "may reflect differing fates for veterans who were 'established' in care and those who were not" (Chokshi 2014, 298). In other words, veterans who cannot access the system cannot be satisfied with the care they receive. This is what Elena meant when she explained that if veterans "haven't had that first appointment with primary care or mental health or whomever, sometimes that's the biggest hurdle."

However, as the clinicians themselves note, no one can force veterans to use the VA, a noncustodial institution. And yet, if the rehabilitative fantasy that is foundational to the VA's moral and political mission is to remain intact, the VA needs to detect veterans' injuries, keep track of them, and demonstrate that it offered rehabilitative services. What regime of power/knowledge is this?

In describing regimes of discipline, governance, and security, Foucault (2007) and post-Foucauldian scholars have traced a shift in how power normalizes populations; in disciplinary regimes of power, norms are imposed by institutions such as factories and schools (Foucault 2007, 63). By contrast, in the forms of power that we now see in security, algorithmic governance, and surveillance, the norm is devised through observation of the population being governed (Chamayou 2014; Foucault 2007; Roberts and Elbe 2017). In practice, this looks like "detection of the exceptional":

> In this emergent economy of security, which is increasingly powered by algorithmic logic and foresight, there is a shift away from processes of normalization (originally discussed by Foucault) towards the detection of the exceptional (Roberts and Elbe 2017, 56-57).

For example, Roberts and Elbe (2017) describe a procedure that governments and international health organizations use to detect disease outbreaks. Traditional public health surveillance methods rely on direct diagnostic data, population records, and laboratory reports, reported to and interpreted by scientists, statisticians, and national health institutes (Roberts and Elbe 2017, 55). By contrast, contemporary "syndromic surveillance" uses non-diagnostic data, such as hospital admissions reports, pharmaceutical sales data, and levels of work and school absenteeism, to monitor for earlier indications that a disease outbreak is in progress (Roberts and

Elbe 2017, 47-48). The algorithmic technologies Roberts and Elbe describe work by constantly surveying the population "in order to detect, determine and report upon that which constitutes the *exception* within the governance of infectious diseases" (Roberts and Elbe 2017, 57, emphasis in original).

Thus, one key difference between disciplinary power and governance and control is that disciplinary regimes impose a norm from above, while other forms of power allow a norm to emerge from the population itself. The latter strategy points to another important feature of regimes of control, which is that they rely on relative freedom of movement. Chamayou proposes that we have entered a moment in history when the dominance of disciplinary power, which depends on fixing bodies in space, has given way to a form of power that can be exercised upon bodies that are in constant motion. In this "targeted society," people's movements are analyzed through "the lashing of an aggregation of data to individually indexed chronospatial paths" (Chamayou 2014, sec. 11). We see this strategy in policing, military intelligence, and marketing, all of which work to discover patterns in people's movements and then target interventions at deviations from those patterns. For example, marketing companies analyze viewers' eye movements over a webpage; urban planners analyze the movements of pedestrians in urban spaces.

In these theoretical terms, veterans' connections to the VA may be thought of as chronospatial paths, and doctors' attention to the consistency of veterans' "connections" to the institution as efforts to monitor deviations from the established path. In a targeted society, there is no specific trajectory imposed on those who are monitored, and "normal" is not a moral position, but rather the empirically-observed frequency of a certain trajectory through a space (Chamayou 2014). That is how targeting works when there are no known targets—monitoring

chronospatial paths *creates* targets. This is a way of thinking and strategizing that creates normativity without a norm, Chamayou writes, and it is animated by a "devouring appetite: to spot discrepancies in order to 'acquire targets,' and this in a mode of thought where, targets being unknown, it is the unknown that becomes targeted" (Chamayou 2014, sec. 12). In theorizing the VA's TBI Clinical Reminder as an instance of scaled-down targeting, I thus suggest that emerging aspects of contemporary social life are being reproduced in the institutional context of the VA.

Conclusion

In this chapter, I have argued that veterans' movement between VA clinics produces a stable, known relationship with the institution. The VA is responsible for veterans in some sense—if post-war rehabilitation is to remain a plausible ideal, veterans must be demonstrably in a process of being rehabilitated; demonstrating the rehabilitative process depends on what I have called veterans' "connection" to the VA. Here, then, is another kind of uncertainty that matters in the management of the population of OEF/OIF veterans: mild TBI makes explicit the uncertainty inherent in medicine, but we can see veterans' whereabouts and the quality of their "connection" to the institution as another pertinent "unknown" when we look at the TBI screen in the larger context of institutions' role in the management of a population that has individual freedom.

My ethnographic point of entry to these dynamics was the screening protocol that was inaugurated as VA policy in 2007. When the VA started screening for combat-related TBI, the "signature injury" was problematized as a latent problem to be detected in a population of OEF/OIF veterans. I adopt the metaphor of a net to describe how the screening procedure operates, and detailed two aspects of its structure: first, the VA's electronic medical record

system (CPRS), which segments OEF/OIF combat veterans from the VA's whole patient population so that screens like the TBI Clinical Reminder can be selectively applied. Second, the TBI Clinic staff are required by Congressional directive to be "relentless" in their efforts to contact and evaluate veterans. Once the TBI screening procedure has guided veterans to the TBI Clinic, the staff scrutinizes veterans' medical records for gaps in their "connection" to VA services. On a practical level, the clinicians' efforts to make sure veterans are "plugged in" is evidence of the VA's unique characteristics as a health care system. Clinicians' assessment of medical charts as evidence of veterans' connections to the VA also presents an opportunity to compare clinical dynamics to larger dynamics of surveillance and tracking that increasingly shape regimes of power and knowledge that operate more generally in the contemporary social world.

Some of the veterans quoted here describe feeling as if they were summoned to the TBI Clinic by an undifferentiated "they" representing the VA. At the same time, the clinicians describe the strangeness of practicing medicine in a context where their patients feel obligated to access care. Veterans and clinicians encounter each other under circumstances that prioritize the VA's institutional agenda, and yet, veterans need assistance and clinicians want to help them. In the next three chapters, I turn to what happens in the TBI Clinic. Once veterans were summoned to the TBI Clinic, how did the clinicians determine whether veterans had sustained a TBI? If being "unconnected" posed some risks to veterans, what were the risks associated with being "connected" to the VA through this process? How did clinicians endeavor to help veterans with vague cognitive symptoms, not specific to any disease, in a specialized clinic organized around brain injuries?

CHAPTER 4. MAKING MILD TBI VISIBLE

> Some patients may not become aware of, or admit, the extent of their symptoms until they attempt to return to normal functioning. In such cases, the evidence for mild traumatic brain injury must be reconstructed.
>
> American Congress of Rehabilitation Medicine 1993

There is evidence of mild TBI at the time of injury, because the injury is marked by physiological disruption of brain function which takes the form of loss of consciousness, memory loss, and feeling dazed, disoriented, or confused. However, by definition, these signs of disrupted brain function last no more than thirty minutes for brain injuries characterized as *mild* TBI. Therefore, from a medical perspective, a defining characteristic of mild traumatic brain injuries is that cellular-level damage to the brain is neither visible on imaging nor detectable with blood tests.

The examinations I observed at the Western VA in 2014 and 2015 were related to injuries that happened between 2003 and 2012. There was no empirical evidence of the injury *within* veterans' bodies—or at least, no evidence that was detectable. Veterans received the same treatment whether they had sustained a mild TBI or not. Yet, there were two important reasons for doctors to spend time diagnosing these past injuries. First, VA doctors were drawn into a national project of advancing knowledge about the lasting effects of mild TBI. Documenting veterans' injuries and their symptoms in a national VA database creates what Didier Fassin describes as a "scriptural trace" (2012, 127), produced by doctors' transcription and translation of veterans' experiences into a national TBI Registry. The second reason for doctors to spend a great deal of time evaluating injuries that they could not heal, I argue, is that from an institutional perspective making the "signature injury" visible in the population of OEF/OIF veterans is an aspect of the VA's realization of its role of rehabilitating veterans.

In this chapter, I analyze the process by which doctors determined whether a veteran sustained a mild TBI. I show that doctors transferred their diagnostic attention to objects and other information from the scene of the injury. Here, I take up gender scholar Jennifer Terry's observation that the "signature wound" represents a shift in the historiography of war that foregrounds injured soldiers' bodies. As Terry writes, military history to date "has tended to focus on specific 'events' (battles, military campaigns, wars)" but the "signature injury" suggests a turn toward constructing "a history of armed combat that foregrounds the wounding capacities of new weapons systems and the damage they can do" (Terry 2009, 221 n. 2). Drawing on ethnographic data, I extend this observation by showing how mild TBI continues to foreground events, though, as Terry observes, they are not battles or strategic orders made by military

leaders. Mild TBI foregrounds the events that injure American soldiers—events that VA doctors are responsible for documenting.

This chapter is an ethnographic account of how mild TBI shifts the historiography of war, and it contributes to ethnographies of the clinic and hospital by demonstrating a diagnostic practice that alters veterans' positions as the examined. I argue that the process of diagnosing mild TBI is more like an archeology of past events than an examination of the body present in the exam room. Veterans were present in exam rooms only secondarily to offer their bodies for examination; their primary role was to provide their memories—an irony of the TBI clinic, where one of veterans' primary complaints was poor memory.

DIAGNOSING THE SIGNATURE INJURY

"Signature injuries" and institutional "transitions" are cultural categories that organize and contextualize veterans' vague cognitive and emotional symptoms, but VA doctors work in a hospital, where diagnosis is still necessary. "Diagnoses are the classification tools of medicine," sociologist Annemarie Jutel writes (2009, 278), pointing to the multiple processes embedded in "diagnosis." Diagnoses label; they sort people and their corporeal states; they shape how value is assigned to those varying states (Jutel 2009; 2011) and they have material consequences, including bringing certain "kinds" of people into existence (Hacking 2006). In all their forms and functions, diagnoses are socially negotiated. Diagnoses are unstable sites of competition and contests of expertise, where multiple forms of authority, experience, and power can be observed in practice, as qualitative research on contested and emergent illnesses shows us (Brown 1995; Epstein 1996, Kilshaw 2009, Finley 2011, Young 1995).

Ethnographers have shown that diagnoses are often "in flux" (Finley 2011, 160) and temporarily "glued together" by practices, technologies, and narratives (Young 1995, 5). Thus, we can see that a diagnosis is not only a label but also an action – "as a process, [diagnosis] is the method of evaluating and adjudicating the physical complaint" (Jutel 2009, 279). Because diagnosis is a practice, it matters where and when (and for what reason) diagnosis occurs. For instance, Rhodes (2000) shows how classifications from the Diagnostic and Statistical Manual of Psychiatry (DSM) are applied to prisoners, and how the classification process intersects with modes of disciplinary practice in the prison context. In an entirely different space and place, Alice Street's ethnography of a hospital in Papua New Guinea (2014) shows that the lack of reliable laboratory testing facilities means that instead of diagnosing patients, doctors treat them as "generally sick" and use a trial and error method of treatment. Diagnosis is not always possible, and even when it is possible, it does not necessarily dictate the treatment. For example, Rhodes (1991) shows that part of psychiatry residents' practical training in an emergency psychiatric unit entailed the young doctors letting go of their assumptions about direct relationships between diagnosis and treatment, and accepting that "diagnosis was true, useful, *and* tentative, even meaningless" (Rhodes 1991, 95, italics in original).

As these studies in various intuitional contexts show, diagnosis is performed in an interaction between a clinician, a patient, and the environment. However, diagnoses are also "scriptural traces" (Fassin 2012, 127); they travel, and become part of larger knowledge-production processes. In thinking about the relationship between diagnostic labels recorded in individuals' medical records and larger scientific processes, I find helpful Lochlann Jain's (2013) observations about randomized controlled trials (RCTs) in cancer research. Jain illustrates what she calls the immortal logic of science, a paradox of clinical research in which the duration of the

research itself is certain to exceed the duration of the lives of the patients involved. The knowledge produced by the clinical trial takes on something of a life of its own because, Jain writes, "the simple yet unspoken premise embedded in late-stage cancer RCT logic holds that nearly all of the subjects in treatment trials will die" because the length of the trial will exceed the participants' lifespans (Jain 2013, 117). Jain shows that when doctors are engaged in medical research that is meant to be generalizable to whole populations of patients, the immortality of the scientific facts they are trying to produce eclipses the imminent mortality of cancer patients.

Jain's paradox of immortal science produced from mortal bodies illuminates a tension that characterizes medical diagnosis: diagnosis jumps scales between individuals and groups. Diagnosed cases can be aggregated into medical knowledge that doctors generalize. This is particularly true in the VA, where the institution has both an incentive to anticipate its populations' health care needs and the technological capacity to produce that information. However, making generalizable medical knowledge occurs alongside clinical practice, which has an entirely different objective—describing the characteristics of unique individual cases (Jutel 2011, 195). Patients are both individuals with unique circumstances *and* members of a population; doctors' assessments matter at both scales. Though the stakes are radically different in the clinical trials Jain describes, the tension between individuals' needs and science's needs holds true in the TBI Clinic. An accurate diagnosis won't change anything for an individual veteran, but gathering the stories of individual veterans is necessary for constructing the "signature injury" of the war.

KNOWING THROUGH TOUCH

Mild TBI's "invisibility" posed no unique problem for the rehabilitation medicine specialists who worked in the TBI Clinic. Not only were the doctors comfortable making diagnoses without relying on imaging or labs, they were skeptical of diagnostic methods that relied too heavily on these ways of knowing what was going on in the body. Their preferred method of empirical discovery was touch: these doctors were accustomed to using their hands to determine a diagnosis and a course of treatment. Using their hands to discern what was going on inside the body was not only their specialty, but a point of pride. Dr. Leila Frederick was a slight, lively woman, in the final year of her residency program at the Western VA. When she explained her specialty, she waved her hands in front of her, smiling, with her fingers spread wide and wiggling, and said:

> Other fields like internal medicine rely so heavily on labs. But I'm limited. I just have these guys! [Her hands.] If you touch someone, you can feel if the hip is off, or if there's a rotation, which you can then identify as contributing to the pain they feel.

Leila said she was "limited" in her diagnostic practice, but then explained what she could know with her hands alone. Further, doctors were skeptical of relying too heavily on X-rays, MRI, or even blood tests to the detriment of their own sensory experience. Elena, for instance, often insisted that, "imaging is not the diagnosis." By this, she meant that even a mechanized image of the body's interior must be interpreted considering other information available. The relationship between a patient's back pain and the radiologic finding of disc degeneration provided an instructive example. Elena explained:

> Someone can say, for example, that they've had back pain for fifteen years and that they have degenerative disc disorder. Okay, you have degenerative disc disorder. That's an X-ray finding. But let's see what's causing your back pain.

Elena's point was that pain may or may not be caused by the disc degeneration; an X-ray finding does not establish a causal relationship between the body's anatomy and a person's pain.[25] Elena continued:

> When I'm doing musculoskeletal medicine, [I have patients who say] "My X-ray shows I have degenerative disc disease, so my pain is due to my degenerative disc disease." And I say, "No."

In describing such interactions with patients with back pain, Elena demonstrated that disrupting a patient's assumptions about a causal relationship between an anatomical condition (like degenerative disc disease) and their symptoms (like back pain) was a crucial aspect of these clinicians' work. The same logic applied to veterans' mild TBI. If a veteran once had a concussion, and presently has cognitive impairments, the concussion is not necessarily the cause of the impairments. Disrupting this presumed causal relationship between past events and present symptoms was also one of the doctors' main strategies for helping veterans (a strategy I discuss in Chapters Five and Six).

Radiologic findings like the degenerative disc disease in Elena's example may not be causing a veteran's back pain, but doctors still had to determine what was causing the pain. More so than other medical specialties, rehabilitation is a hands-on discipline. Doctors in this field touch and move patients' bodies to diagnose pain, and they use physical therapy, ultrasound, and injections to manage patients' pain. When Elena and her team were not working in the TBI

[25] See Jensen et al. 1994 on lack of correlation between anatomical finding of disc degeneration and back pain.

Clinic, they treated the rest of Western VA's patients who had pain syndromes, neck and back pain, muscle and joint injuries, prostheses, stroke, and injuries related to sports and work.

The TBI clinic doctors were excited by the opportunity to help young veterans who were experiencing physical pain, and visibly animated by the opportunity to use their specific skills to solve a problem. As physiatrists—rehabilitation medicine doctors—this was their specialty. When I asked one young doctor to explain his specialization to me, he said that the field of rehabilitation medicine is characterized by both the desire and the ability to know the mechanics of a physical injury and the pain it produces. He compared his practice to other specialists' ways of knowing:

> [Other] doctors will order X-rays for pain—but why? How is an image of bones, with no muscle, going to show you about pain? You have to look at the anatomy first.

To "look at the anatomy" in this sense was to know and understand the dynamics of the inside the body in the three dimensions of sensorial knowledge that constitute the mode of clinical attention Foucault characterized as the gaze (1973). For physiatrists, touch is primary among those senses.

One morning, I observed Leila with a veteran who had pain in his knee. This was an opportunity to watch her "look at the anatomy." The veteran was in his late thirties; he had been deployed to Afghanistan and had been out of the Army for about three years. His knee pain was bothering him more than the rest of his symptoms. Exams in the TBI Clinic typically involved at least sixty minutes of everyone sitting in chairs, talking. Often, the exam table was not used at all. What followed in Leila's examination of this veteran was a significant departure from what I had become used to. At Leila's instruction, the veteran sat on the vinyl exam table and rolled his

jeans up past his left knee. Leila asked the veteran to lie on his chest, with the sole of his left foot toward the ceiling. Standing to his side, she used her hands to manipulate the lower part of his leg and his knee. Then she asked him to turn over onto his back, with his feet flat on the table. At this point, the doctor got up on the exam table with the veteran, sat on his left foot, and pulled his knee towards her, away from his torso. She then asked the veteran to roll to his side. Still sitting on the exam table at his feet, she pushed his bent knees into the table. At moments during the examination, the veteran winced in pain, including when Leila used her hands to gingerly move his leg and knee joint through its full range of motion. At the end of her "look" at the veteran's anatomy, Leila wrote a detailed report of her investigation of the mechanics of the veteran's knee pain and a referral to the main Physical Medicine and Rehabilitation clinic in the VA hospital, where the veteran would receive additional diagnostic observation and physical therapy.

Leila's examination of this veteran's knee pain was more physical than what happened most days in the TBI Clinic, but touch was not entirely absent from doctors' evaluation of mild TBI, either. Doctors used their hands during a routine set of tests to rule out the presence of nervous system lesions. The exam involved tests of balance, reflexes, basic movement and strength of the limbs, tests that someone with a spinal cord lesion or an otherwise undetected stroke might fail, but preformed on thirty-year-old, athletic military veterans typically yielded little useful information. Nonetheless, as Elena once put it, mild TBI is a central nervous system issue and therefore, central nervous system exams were part of the VA's protocol.

When doctors touched patients during these tests, it often resulted in interactions that were awkward and funny, and brought into relief just how heavily verbal most interactions were—surprisingly so, in a medical clinic. When Leila and the other doctors touched patients, they seemed, to me, most recognizable as doctors. It was a practice I rarely saw during my

fieldwork. At Western, I was primarily around young, relatively healthy veterans, people whose interactions with doctors and other clinicians were mostly verbal. People rarely touched each other in any way other than a regular, informal touch like a handshake. Doctors touched patients so infrequently that I never got used to seeing it. When Elena and Leila touched veterans in the TBI Clinic, for instance, these were moments (sometimes, seconds) of physical interaction that punctuated over an hour of talking.

Leila seemed to provoke many amusing reactions during these brief physical exams. Funny and friendly, she was barely over five feet tall and athletically-slender—as a child, she had a brief but successful career as a gymnast. She played up these traits as she interacted with the mostly young, male, military veterans. Once, when Leila asked a veteran to take his shoes and socks off in order to perform a neurological test, he hesitated, telling us that he really did not want to do that because his feet might smell; he had just come from the gym. This veteran was thirty-two years old, roughly the same age as both me and Leila. As he removed his socks and athletic shoes, he laughed uncomfortably, and admitted that not only had he not expected any physical examination, but he certainly had not expected to find a young woman doctor and a young woman anthropologist at the VA. On another day, Leila examined an enormous young man, probably six-foot-six and solidly muscular. Performing another routine nervous system check, Leila positioned the veteran in the middle of the exam room, standing with his eyes closed. The test involved (lightly) shoving the veteran in several different directions to test his balance. Leila often cracked jokes during this procedure, but this veteran dwarfed her, and the test ended in the three of us laughing and Leila explaining that she felt like a small child pushing on an adult from whom she was seeking attention.

It was extremely rare for these tests to yield information that was useful for identifying the cause of veterans' various complaints. They were performed as a precaution—if one of the tests produced an abnormal result, the doctors suspected the presence of a nervous system lesion. I never saw this happen. Of these tests, Elena said:

> We don't learn much from the physical exam. Maybe five percent [of our information comes from the physical exam]. It's mostly in the history. But to adhere to the Congressional mandate, we have to see them face-to-face.

The Congressional mandate Elena referred to was the required in-depth evaluation offered to any veterans whose TBI Screen was positive (discussed in Chapter Three). Beyond the basic obligation to follow the policy, doctors needed to see veterans in person to assess their physical pain. As Leila put it, to determine the cause of musculoskeletal pain, "you have to place hands on." Leila's manipulation of the veteran's knee involved "placing hands on" to determine the anatomical biomechanics of his pain. These "hands on" ways of knowing are the hallmark of Elena and Leila's medical specialty and in the TBI Clinic, doctors had some opportunities to produce knowledge through touch.

In the strictly visual sense, Leila could not "see" the mechanics of a veteran's knee pain, but she could know about the anatomical mechanics and, in so doing, her "seeing" was consistent with Foucault's description of the gaze (1973). An old knee injury like the one Leila examined was also consistent with classical modes of clinical attention because it presented a door to be unlocked with a key found inside the body. The search for that key was Leila's favorite part of her medical practice. She enjoyed applying her understanding of human biomechanics to "figuring it out," as with this knee injury. Elena, too, said that the reason she specialized in Physical Medicine and Rehabilitation was that she liked to "solve the puzzle."

Both doctors enjoyed using their own bodies as instruments and their cultivated sensory knowledge to solve a puzzle. In Leila and Elena's descriptions of their profession, diagnostic medicine was a stand-off between a mysterious disease process and the sleuthing doctor (cf. Brown 1993). The conflict between the disease process and the doctor replicates the conventions of the genre of classical detective stories, when the "original mystery (whodunit—and how?) becomes encased in a secondary mystery, that of mastery (how did he—the detective—do that?)" (Saunders 2008, 143). When this process works, it reinforces stories of medical heroism in which the doctor triumphs over the mysteries of disease and thus, over patients' suffering (Taylor 2003, 175). Solving the puzzle, experiencing clinical mastery, and triumphing over the mysteries of disease is enjoyable. But this diagnostic intrigue, Saunders (2008) observes, can be threatened when medical imaging technologies, such as CT scans, "[make] things too clear, too quickly—by turning search and inference into mechanical revelation and rote response, and by substituting quantity of information for the image of a unique totality" (Saunders 2008, 149).

I recount these moments of hands-on doctoring to show that working in the TBI Clinic was—in some significant ways—uncomfortable, because clinicians' reliable diagnostic tools were not helpful. Their primary task was assessing distant histories of mild head injury, and this could not be achieved by "looking at the anatomy" using their hands.

Because mild TBI was an injury that resisted mechanical revelation, one would think it would present an intriguing puzzle for doctors like Leila and Elena to solve. To the contrary, from some doctors' perspectives, the TBI Clinic held a low position in the economy of diagnostic intrigue. Leila once characterized the work of diagnosing mild TBI as, "honestly, kind of boring." In contrast to a general practice clinic where doctors determine which disease—of *all* of the diseases known to biomedicine—is the culprit in this *particular* case, the TBI Clinic was a

specialty clinic. The drama that unfolded in the TBI Clinic was so contained that it revolved specifically around one question: did the veteran sustain a TBI? The question had only two possible answers, and the answer a doctor chose would not change the course of treatment. As such, the question was not particularly intriguing to doctors, at least, not at the scale of the individual veteran who was present in the exam room.

At the time of my research, VA doctors across the country had determined that 66,454 veterans who were never diagnosed by the military as having had a concussion had, indeed, sustained mild TBIs (US Department of Veterans Affairs 2015). If there is no accessible objective evidence of mild TBI in veterans' bodies, and doctors could not use touch to assess the exact cause of veterans' cognitive symptoms, where did these numbers come from? In the rest of this chapter, I show how doctors "know" about a years-old injury that leaves no accessible traces of physical evidence in the body.

DAMAGED VEHICLES AS CLINICAL EVIDENCE

The week after Christmas, Dr. John Moy and I met Costa Novak, a very tall and broad-shouldered, fit-looking veteran with cropped hair. He wore a black baseball cap, with a pair of sporty sunglasses lodged over the brim. He kept his cap on when he sat in the vinyl exam room chair with his legs slightly splayed and his hands on his knees, bouncing his legs rapidly. Although the injuries Costa described to John had happened nearly ten years ago in Afghanistan, Costa was not yet thirty years old. He had a relatively long career in the Army, and he was medically discharged only three months before this visit to Western. In those three months, Costa had started taking college classes and was spending the rest of his time at home with his children while his wife worked.

John asked him, “What are your expectations for this visit today?”

“Answers, maybe,” Costa said. “If there’s something wrong with my head. If that’s what’s causing me to be dizzy and get angry so much. Maybe. I don’t know.”

“Were you dizzy and angry before?” John said.

“Before the service? No.”

“What were you like before?”

“I was always happy, I guess, and very out there [outgoing]. Honestly, it’s been so long since I’ve been that way, I go off what other people tell me.”

“And what do they tell you?” John wanted to know what other people told Costa about *when* they noticed his personality change, but Costa simply repeated what his friends and family told him about how he was now.

“That I’m angry a lot,” he said. “That I’m snappy.”

But Costa did not seem angry in the Exam Room. When John asked him about his symptoms, he talked animatedly about his young kids, and his descriptions of playing in the yard and running errands became the context for the physical pain and irritability he recounted to John. Costa told us that he loved to be outside playing sports with his kids, but that “being snappy” bothered him.

“I’m quick to be irritable,” he said, still sitting with his palms resting on his knees. “I love the kids. But I’m yelling at them for stupid stuff, and I think, ‘Why did I just do that? Why am I yelling at them?’ And I don’t remember what I yelled about. For you to yell at a child, you should be able to remember what for. And I don’t. It’s very frustrating.”

John looked down at the stapled paper forms Costa had filled out by hand. From his seat in the wheeled black office chair about two feet to Costa’s right, John said, “You describe on this

paper that you were exposed to a vehicle-borne IED in 2005." Then John explained how he would determine whether Costa had been concussed—by getting a good story.

> The most important thing for evaluating for TBI is getting a good story. Because these symptoms are general—irritability, poor concentration—you can have those from anything. So, can you tell me what happened?

Costa said:

> We were on convoy. I was unconscious for about one or two minutes. It wasn't that long. I saw that our truck was swerving off the road, but I couldn't see why. The next thing I knew I was being pulled out of the truck. Our driver saw a black sedan coming at us, and if he hadn't swerved, I wouldn't be talking right now. It exploded maybe ten meters from us, where they thought the truck was going to be on the road. They pulled us out of the vehicle pretty quick, but the blast just completely messed all of us up.

John did not dwell on any of the details about the close call, or even Costa's assertion that he had been knocked unconscious.

Without hesitation, John asked, "What happened immediately after you came to and were pulled out?" John was looking for information that would corroborate Costa's memories of the explosion.

"It was hectic," Costa responded. "We all just checked each other—ten fingers? Ten toes? —I didn't see anyone bleeding and we weren't medevac'd. We all made it to the base, in another vehicle in the convoy. And I thought I was fine. I went to sleep, and when I woke up in the morning I couldn't move."

"Did you see a doctor or a medic at that time? Did anyone check you out?"

"I [told the medic] I was fine. I was nineteen years old at the time and when I said I was good to go I think they just took that for what it was. And I was pissed. I was really pissed that that had happened. I clearly wasn't thinking right and I *was* confused about everything that had happened. It was just one explosion, but I felt so much more happened because I was so jumbled. I was so mad. *So* mad. And being so angry about what had just happened, I just wanted to get back out on another convoy [and attack some people]."

Costa's emotional reaction to what had happened was not terribly relevant to John's task. It was interesting that Costa remembered how mad he was, and that he was so "jumbled" that he seemed to have overreacted to one explosion. John was a sympathetic doctor, and often got wrapped up in veterans' stories, but ultimately he was tasked with determining whether this explosion ten years ago had resulted in a traumatic injury to Costa's brain.

After John examined Costa's back and explained what kind of physical therapy was available at the VA, John returned to the problem of Costa's irritability. He explained that problems like anger or "being snappy" with the kids could have many causes, and therefore there were many solutions they would try. Then John left Costa alone in the Exam Room, and walked down the hall to confer with Elena.[26] As we walked, John told me that he thought Costa had indeed sustained a concussion, but he was not sure and wanted to see what Elena thought.

Elena's office was brightened that day by a colorful bouquet of flowers, delivered as a gift from a veteran's mother. Elena sat behind her desk and John and I settled into the two patient chairs facing her. Elena was looking at her computer screen, on which she had been reading Costa's records. She listened to John while jotting notes with a pencil on a yellow legal pad.

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[26] Elena's supervision was a routine part of the resident doctors' education, and the permanent VA employees' oversight of veterans' care. The VA's partnership with universities across the country has been a significant part of its institutional history since the relationship was initiated in the 1970s as a measure to improve patient care (see Chapter One).

John said, “His story is this: In 2005, while on a convoy, they encountered a VBIED [vehicle-borne IED]. He had loss of consciousness, had no memory of the event, and was confused afterwards—the trinity of TBI. He and his other people were able to get into another vehicle and get back to the base.”

Immediately, Elena stopped him. “So, their vehicle was damaged?”

“Yes,” John responded.

This was a piece of information that Costa had provided, but of which John had not fully appreciated the importance: Costa’s unit traveled away from the scene of the explosion in a *different* truck. This indicated to Elena, the more experienced doctor, that the bomb Costa survived was large and powerful enough to have damaged a bomb-resistant armored US military vehicle. The damaged truck, for Elena, was secondary information that provided a kind objectivity, a transparency into Costa’s history, despite that history not being inscribed on his body in any accessible way. The damaged truck indicated that the explosion was forceful enough to cause a concussion, and so, the doctors diagnosed Costa as having had a mild traumatic brain injury. In the task of diagnosing Costa’s body, the most relevant information was that a machine had been damaged.

When John told Costa’s story to Elena, he focused on Costa’s self-reported loss of consciousness and his foggy memory of the event. Although both of those things might indicate that he had been concussed, Elena was primarily concerned with how the explosion that had injured Costa also affected objects around Costa’s body. She shifted her attention away from the veteran himself, focusing instead on a piece of military equipment. The information they needed was about the truck and that information was contained in the story, not in Costa’s body.

UN-CATEGORIZING JUSTIN'S DIAGNOSIS

In the above example, the most important detail in Costa's story was that his armored vehicle had been so damaged by an explosion that detonated ten meters away that it could not be driven away from the scene. Costa's ride in a different truck became sufficient evidence for the doctors to confidently diagnose Costa as having had a mild TBI, even though the injury was a decade old and could not be detected in his body.

Later the same month, Justin Lozier came to the TBI Clinic. Justin was the veteran whose story opened this dissertation; his friend was killed in the "same" truck that hit the "same" bomb as the one that injured Justin in 2010. Justin's reason for coming to the TBI Clinic was that he had recently moved west from his home in New York, and he wanted to "get set up at the VA." He had been given the four-question TBI screen, referred to the TBI Clinic, and there he met Dr. Leila Frederick.

Justin's heavy plaid flannel shirt was unbuttoned enough at his neck to reveal a scar along his right clavicle and a tattoo extending from his right shoulder over his chest. His left wrist also was tattooed.

"Is it a full sleeve?" Leila asked, gesturing toward his left arm, with sincere interest. Justin was twenty-five at the time, and Leila, almost finished with her medical residency, was not much older.

"No," Justin said, cool and expressionless, as if he answered this question often. He used his right wrist, the one with the silver bracelet that memorialized his friend who had died in Afghanistan, to mark where the tattoo on his left arm stopped just below his bicep, but he gestured that that his other shoulder was covered. This chit-chat about his tattoos was an ice-

breaker of sorts, and it comprised basically the only examination of Justin's body that Leila would perform during their meeting.

Moving on, she asked Justin about his injuries.

"Can you please tell me about the first injury—the blast in 2010?" Leila said.

Justin responded, "What do you want to know about it?" His tone was perplexed, not confrontational.

"Just what happened. The circumstances."

"I was the driver. Our convoy came across some Afghan Police Force, and we stopped to check that they had papers for their weapons, and they did. So we drove through where the vehicles were parked and then we turned left and that's when we hit the IED."

Leila said, "What happened after that?"

"I remember when I woke up. I was underneath the steering wheel."

"How long were you out?"

"Just a few seconds."

"Were you wearing a helmet?"

"Yes."

"Did you have any injuries?"

"I had a concussion. I bruised my sternum," Justin answered.

"Did they do anything for you at the time?"

"We were on light duty for about a week," he said. "There was a watch on us for 24 hours, because of the concussion."

Leila hesitated, her eyes lingering on the computer screen. She asked, "Did you have any other symptoms after the blast?"

"I think I broke through the seatbelt, and hit the ceiling, so my head and neck hurt."

Leila paused here, again, and smiled self-consciously while she looked away from Justin. She made a number of false starts to her next question.

"But as far as… did you have any other symptoms?"

Because I was familiar with this process, I knew that Leila was trying to ask an open-ended question, eliciting Justin's story by facilitating his description of the details of an event, as Elena had taught her. However, she was failing because Justin continued to report only that he had been diagnosed with a concussion. He was not giving Leila more details about the event itself.

I imagine that Justin considered the diagnosis to be shorthand for the details that Leila was trying to elicit, but from her perspective, the diagnostic label obscured the information she needed. This cursory labeling was precisely what the doctors try to avoid. To make an assessment, Leila needed details about the circumstances that would indicate the state of Justin's central nervous system when he was injured. The point here is not that Leila distrusted Justin's declaration that he had had a concussion, but that she needed more information to arrive at her own diagnosis. Leila's determination needed to be grounded in evidence that she obtained herself, and Justin's statement, "I had a concussion," black-boxed the event which was the source of the information she needed.

GETTING A "GOOD STORY"

When John asked Costa to explain what happened, Costa gave a "good story" that included the details of how the convoy had been attacked and what happened immediately after. By contrast, there was no "good story" in Justin's perfunctory declaration, "I had a concussion."

In the TBI Clinic, doctors relied on veterans' stories as their primary source of diagnostic information.

In the TBI Clinic "good stories" were not narrative medicine, in which patient's stories are part of healing (Charon 2006), nor were they illness narratives, sick persons' experiences of living with disease (Kleinman 1988; Frank 1995). Diagnosing mild TBI though "good stories" was also not a process of giving meaning to therapeutic events by placing them within a larger therapeutic story, what Cheryl Mattingly calls therapeutic "emplotment" (1994). "Good stories" were not holistic, wide-ranging stories of a veteran's experiences or current understanding of their bodies; like conventional performances of clinical competence, doctors used "good stories" to bracket off certain kinds of experiences in order to focus on others (Taylor 2003).

In "getting a good story," VA doctors performed standard biomedical diagnosis to the extent that it was possible given the challenges presented by post-acute mild head injuries. That is, doctors treated "good stories" as more or less transparent windows to the biological processes they were interested in categorizing (in this case, neurological injury). They made a categorical diagnosis by sorting a great deal of information into discrete categories. But when doctors used veterans' stories about the past to do their work, they displaced the same diagnostic question to another field: instead of examining the body, they examined historical events.

Amidst all the uncertainty that surrounds these "invisible" injuries and their effects on veterans, VA doctors remained committed to uncovering some version of clinical truth. Thus, these diagnoses were not disruptive of the clinical gaze itself, but veterans' positions as subjects of the clinical gaze shifted in so far as the story was focused on past events instead of on what the veteran's body could reveal to be true. In diagnosing mild TBI, doctors' inquiry was oriented to uncovering a truth about a pathological process, and veterans' speech was treated as a

transparent way to access the information that they needed, which was located outside of the body.

For example, during Dr. Leila Frederick's first week at the TBI Clinic, she evaluated a veteran and reported her impressions to Elena, who again took notes with a pencil on a pad of paper. Elena's first question was, "How long did [the veteran] lose consciousness for?" Leila said she did not know. Elena provided some suggestions for eliciting this information:

> When [the veterans] come to, what's around can sometimes give them a sense of how long they were out. For instance, they might remember, "I came to and everyone was out of the vehicle," or "I came to and everyone was still in the vehicle." It gives you a little bit of an idea what went on.

The length of time for which the veteran was unconscious was important information, but ideally, what the veteran *said* would be corroborated by secondary information, such as the first thing a veteran remembered after regaining consciousness: were they in the same physical location as when they had lost consciousness? Had the time of day or the surroundings changed? Elena instructed the doctors in this strategy:

> You don't want to ask about loss of consciousness. Ask what they saw, felt, and heard. Ask: what happened? And then what happened? The objective is to walk the patient through an event.

The practice of eliciting "good stories" was not a method that Elena and her team came up with on their own. This method for "identification of a remote traumatic brain injury" was adapted for the VA by a team of researchers (Vanderploeg et al. 2012). Doctors are instructed to use open-ended questions to facilitate veterans' "freely told, spontaneous description of the event and immediate symptoms or problems" (Vanderploeg et al. 2012, 549). The expectation of

"spontaneity" was one of the ironies of this recording process. All the interactions between doctors and veterans around TBI were highly orchestrated and burdened by conflicting obligations.

Elena found ways of getting secondary information, and "good stories" that included these details would indicate how long someone was unconscious. The secondary information referenced material objects, surroundings, or other people present during the event that caused the injury. "Good stories" included details about broken seatbelts, lost helmets, damaged vehicles, and other soldiers who were unconscious, laughing, or helping. A "good story" tethered veterans' subjective experience to objective stuff in the world. Doctors interpreted such details as plausibly objective diagnostic information.

Once the doctors shift the diagnostic question away from the body to past events, they apply the clinical guidelines for diagnosing mild TBI. Doctors consider a traumatic brain injury to be "mild" when unconsciousness does not last more than thirty minutes, and when alteration of consciousness (amnesia, confusion, etc.) does not exceed 24 hours (US Department of Veterans Affairs/DoD 2009). To return to the examples from above, for instance, the explosion that injured Costa was large enough to cause a concussion, as evidenced by the damaged vehicle. But he regained consciousness quickly enough to participate in checking the others at the scene of the explosion. Therefore, the doctors concluded, he sustained a *mild* traumatic brain injury. Likewise, the fact that Justin woke up underneath the steering wheel was a good enough indication that he was not unconscious for very long—if he had been unconscious for more than thirty minutes, the doctors' logic went, someone would have moved him from the vehicle.

Displacing diagnostic attention from the body to events did not resolve the uncertainty associated with diagnosing these injuries. In fact, after all this effort, the diagnosis of mild TBI

did not change the treatment that a veteran was offered (Chapters Five and Six). Eliciting detailed stories from veterans was not only diagnostic due diligence; the information the doctors elicited was also complied in a national database.

The VA's Traumatic Brain Injury Veterans Health Registry (hereafter referred to as the Registry) is a national database of veterans' injury circumstances, created in response to the same legislation which prompted the creation of the Polytrauma System of Care in 2003. When a veteran was evaluated for a history of mild TBI, doctors populated the database with information obtained from these veterans. The data compiled in the TBI Registry was maintained by the VA's Central Office in Washington, DC, and analyzed by VA researchers who study mild and moderate TBI.

The TBI Registry was distinguished from the VA's many other forms and checklists by two characteristics: first, it required doctors to gather extremely detailed information, and second, it was a research tool. It was also significantly more work. Unlike the short, standard sets of questions about exercise, diet, and alcohol use that other staff were prompted to ask all veterans, the TBI Registry included over eighty questions. At first glance, the Registry appeared to have only thirty questions, but the form expanded as doctors used it. They encountered a series of mostly multiple-choice questions whose answers they provided through clickable circles and squares. Thus, the thirty questions on the form came along with thirty additional boxes to be checked to indicate the presence or absence of specific symptoms.

Training a new resident physician to use the TBI Registry website one morning, Elena explained how each question generates more questions, and how the website was set up to compel doctors to answer it completely. An undifferentiated "they" sending orders from the VA's Central Office in Washington was conveyed in the way Western's doctors encountered the

form, with its mostly auto-populated fields, and the spatiotemporal network it drew them into. The form itself was also somewhat personified. As Elena explained how to use it, she referred to the form as an active participant. For instance, without an answer certain questions, Elena explained, "it won't let you advance." And then, "it asks more questions." Hovering over the shoulder of the resident who was seated in front of the computer screen, Elena scrolled through each question on the screen:

> In the question about whether it's [the injury] deployment-related, if you click *yes* you have a whole bunch of other questions to answer now. In the event of a blast, we want to know if they actually felt a wall of air. If you go outside and a 45 mph gust of wind comes, it doesn't cause a concussion. Central Office wants to know all the mechanisms of injury—the air, did they hit their head, were they hit by flying debris.

Elena had been the director of the clinic from its inception, and she was accustomed to the heavy administrative workload. Training residents to complete this form was routine for her; as an attending physician, she trained a new resident rotating through the clinic every six weeks. She described the section of the TBI Registry that collects data about the mechanisms of blast injuries quickly and without fanfare or much extraneous commentary.

> So, this is the primary, secondary, tertiary, quaternary mechanisms of injury that come from a blast. And if you click *yes* for 'loss of consciousness', it asks how long.

The resident to whom she was explaining this form, however, was astonished. Staring at the computer screen in a kind of earnest awe, he mumbled, "Wow, this is just so much information."

In her overview of the Registry, Elena reached the question about the TBI diagnosis, toward the end of the questionnaire—the question that yielded the data about the 66,454 veterans with previously-undiagnosed mild traumatic brain injuries. The website displayed on the computer screen read:

Are the history of the injury and the course of clinical symptoms consistent with a diagnosis of TBI sustained during OEF/OIF deployment?

(0) No (1) Yes

The resident doctor who had marveled at the sheer amount of information he was being required to collect in the TBI Registry made another striking observation. Laughing quietly, the resident doctor said, "They forgot the maybe."

Elena responded without hesitation. "They took it out," she said. "We have enough information to say *yes* or *no*. When there's a grey area, I lean toward yes, but we have to say *yes* or *no*. We can't say maybe."

To recall the "undone" science of mild TBI that I discussed in Chapter One, doctors in the TBI Clinic were working in a context of uncertainty about the causal relationship between veterans' old injuries and their present symptoms. Answering the above question required a bifurcation between the past event of the mild TBI and the presently symptomatic veteran. Doctors can know whether the event was a concussion; they can't know whether the veteran's symptoms are from that event. When Elena said that they "can't say maybe," she meant that the TBI Registry required an answer. At the same time, a productive uncertainty was fundamental to the doctors' ability to provide care for veterans. In Chapters Five and Six, I take up this therapeutic strategy, and I show how this data production affects the individual veteran-patients

who were subject to it, and the action that clinicians took to address the problems experienced by the veterans whose stories were populating this database.

Conclusion

In this chapter, I have shown how a clinic staffed by physiatrists is tasked—by Congress and the VA—with evaluating veterans' histories of mild TBI. Rehabilitation doctors use touch to understand the mechanics of physical injuries—which, even when they happened years ago, leave palpable physical evidence in the body's musculature. When clinicians like Elena and Leila touched veterans, they seemed most like doctors (and veterans seemed most like patients) because they were engaged in a recognizable diagnostic ritual, in which their attention was focused on detecting *in the body* traces of evidence of the disease or anatomical disorder causing a person's pain. To detect post-acute concussions, however, a doctor's attention needs to be focused elsewhere. The body provides no discernable evidence of a disease process. That does not mean that no evidence exists. Diagnosing mild TBI requires doctors to alter their practice in two related ways: first, they have to obtain their information through talking, rather than through touch; second, diagnosing mild TBI shifts doctors' attention from away from veterans' bodies, and they instead focus on past events.

The VA's moral obligation encompasses both caring for individual veterans and producing knowledge about war-related health problems that may affect entire generations of military veterans (such as illnesses caused by exposure to Agent Orange, Gulf War Syndrome, and respiratory problems caused by so-called "burn pits" in Iraq). Thus, the work of the VA and its clinicians involves both the supposedly universal human body which is the subject of biomedicine, and another not-quite-universal body: the veteran's body. VA researchers (along

with their colleagues in the Department of Defense) are tasked with understanding the characteristics of this veteran's body—the generalizable one—what it has been through; how it is supposed to behave after it has been exposed to blasts; after combat; after leaving the military; what it is due in exchange for its "service" to the nation. The VA's national TBI Registry that I have described in this chapter is part of this knowledge-production project. The process that takes place in the TBI Clinic exam rooms transforms information about the circumstances under which an individual was injured into generalizable information about veterans. Doctors and veterans together are drawn into a process of transforming individuals' experiences into scientific and medical knowledge about the health effects of war. This information is presumed to be crucial to answering such questions as: what did the blast injuries do to the bodies of this group of people? What will happen to them as they age?

CHAPTER 5. ANXIETIES ABOUT ATTENTION

> We have [a list of] twenty-two symptoms that *can be* post-concussive. I challenge you to tell me which one you've never had in your life.
>
> Dr. Elena Beech, director of the TBI Clinic

> Disability, then, is not a fixed *thing*. It is an elastic and dynamic social category. It is not an objective condition. It is a set of socially produced, highly mutable, historically evolving social identities and roles.
>
> Longmore 2003, 239, emphasis in original

In his ethnography of the formation of post-traumatic stress disorder (PTSD), Allan Young shows that PTSD is a disease of time. In Young's account, traumatic time describes the progressive, causal relationship between a traumatic event, a person's traumatic memory of the event, and the syndrome that is called PTSD. The traumatic event itself "has weak specificity [for predicting the syndrome], since many people who experience these events do not develop the symptoms of full-blown PTSD" (Young 1995, 120); the crucial feature of the syndrome is traumatic time. The traumatic memory persists, pathologically, because it is out of time; someone with PTSD experiences past events as if they are happening in the present. Young

shows that traumatic time is at once the mechanism by which PTSD is diagnosed and the way it is treated. To treat veterans' PTSD, psychiatrists reconfigure the traumatic memory into a less intrusive memory. Therapies work by rearranging traumatic time. Young writes, "the net effect of such schemas is to get traumatic time to run in the right direction: *from* the etiological event *to* the post-traumatic symptoms" (Young 1995, 141, italics in original).

Young's analysis of PTSD clarifies the (entirely different) case of mild TBI because it establishes that the relationships between *past* injurious or traumatic events and *present* symptoms are not fixed. Clinicians can intervene in patients' experiences by reconfiguring relationships of causality. In some cases, past events cause present symptoms, and the etiology of an illness may include a traumatic event. Other times, there is no causal relationship between an event and a set of symptoms. Veterans in the TBI Clinic were bothered by their inability to remember things in their daily lives. In the logic of the clinic that I describe in this chapter, veterans' memory problems can be plausibly caused by many things: hearing impairments, pain, hypervigilance, depression, and lack of sleep can all cause an inability to pay attention, which in turn, can cause trouble remembering. As the relationship between traumatic events, memories, and PTSD is variable, the relationship between past brain injuries and veterans' present cognitive impairments is a malleable one, and therefore, doctors direct their attention and interventions to that malleability.

Thus far in this dissertation, I have been primarily concerned with the VA's efforts to track, assess, and document veterans and their injuries, and how those efforts bring clinicians and veterans together in the TBI Clinic. In this chapter, I turn to the clinicians' therapeutic efforts. I engage with literature from Disability Studies that shows the dynamic relationship between impairments and their meaning in social life. Putting these insights in conversation with

anthropological accounts of the productive nature of uncertainty in medicine, I show how VA clinicians foster uncertainty about veterans' symptoms. In this chapter, I introduce two ideas to illustrate how clinicians interpret the hazards posed by the VA's TBI-related protocols: iatrogenic harm—damage caused by medicine, and another metaphor related to the VA's "wide net" —bycatch. Finally, I show how clinicians' interpretations of the hazards of tracking, assessing, and documenting lead to a therapeutic strategy that reconfigures the meaning of veterans' symptoms—a strategy I conceptualize as "expanding the etiology" of post-combat cognitive problems. Here, the processes associated with framing mild TBI as a "signature injury" show how an institution's very attention to social problems can become a problem for the people drawn into those processes.

DISABLED SUBJECTS

The medical discipline of physical rehabilitation originated after World War I, when it was developed as a method of "human conservation," meaning that it was conceived as a project of restoring damaged soldiers' bodies—and particularly their capacity to work—through orthopedic surgery and physical therapy (Linker 2011, 57). In an account of the relationship between war and rehabilitation, historian Beth Linker writes, "rehabilitation was born as a Progressive Era ideal, took shape as a military medical specialty, and eventually became a societal norm in the civilian sector" (Linker 2011, 7). Broadly, rehabilitation "enables persons with disabilities to interact with their environments and maintain optimal physical, sensory, intellectual, psychological, and social function levels" (Albrecht 2015, 148). From its early days,

physical rehabilitation has directed these efforts at the body, with the goals of self-determination and independence.[27]

Rehabilitation medicine coalesced as a field to treat people who had irreversible injuries, such as soldiers with amputated limbs, and the field grew to include impairments and conditions with no cure (e.g. Parkinson's Disease, blindness, the effects of a stroke). Traumatic brain injuries fall under the purview of rehabilitation because like other neurological conditions, doctors can treat symptoms and improve patients' functionality, but they cannot erase the problem. For instance, when a limb is amputated, and biomedicine cannot produce a cure (in the strict sense of eradicating disease), the mission of this particular branch of biomedicine is to restore functioning with therapies and prosthetics (e.g. Messinger 2010b). Rehabilitation, then, deals with conditions that trouble the biomedical mission of curing. However, insofar as the underlying ideology of "curing" is restoration, rehabilitation remains grounded in the ideology of cure, particularly in one key way: rehabilitation seeks to return a person to a state of nondisability. As disability scholar Eli Clare observes, curing is a project of restoration:

> First, cure requires damage, locating the harm entirely within individual human body-minds, operating as if each person were their own ecosystem. Second, it grounds itself in an original state of being, relying on a belief that what existed before is superior to what exists currently. And finally, it seeks to return what is damaged to that former state of being. (Clare 2017, 15).

The impetus to "restore" is rejected by many disabled people, including Clare, for whom "an original nondisabled state of being doesn't exist" (2017, 15). Clare writes:

[27] For a critique of the centrality of independence, see Kittay and Feder 2002.

> The version of me without tremoring hands and slurred speech, with more balance and coordination, doesn't originate from my visceral history. Rather it arises from an imagination of what I should be like, from some definition of *normal* and *natural* (Clare 2017, 15, italics in original).

Critical theorist Maurice Stevens similarly rejects the notion of restoration as it applies to trauma, noting that trauma therapies promote a "recuperative fantasy"—a fantasy that bodies and minds have an original state to which they can be restored after a trauma (Stevens 2011, 175).

Brain injury frustrates rehabilitation medicine's usual interventions in another way. Not only is there no way to restore the brain to an original state of being, and therefore no "cure" to offer young veterans who are worried about their cognitive function, but there is no technological "fix." No pharmaceutical drug, device, or prosthetic exists for someone whose cognitive processes—their very *thinking*—is disrupted by a brain injury (Webb 1998). People can adapt to their environments and their tasks, using various technological aids (e.g. iPhones), but these technologies do not restore thinking in the way that, for instance, a wheelchair restores mobility. Physiatrists and therapists working in retaliation medicine can neither cure nor fix veterans' cognitive processes, and instead, as I will show in this chapter, their therapeutic interventions are directed at reconfiguring the meaning of veterans' symptoms.

Beginning in the 1970s, academics and activists demonstrated that disability is socially constructed (e.g. Hahn 1988; Union of the Physically Impaired Against Segregation [1975]1997; see Shakespeare 2006 for a critical overview). Their starting point was a critique of what they called "medical models of disability," those ways of conceptualizing disability that had been institutionalized by the field of rehabilitation medicine. Rehabilitation medicine, activists and scholars argued, treated individual disabled bodies as deviant and broken, and the field of

rehabilitation emerged around efforts to "fix" them. Rejecting medicine's efforts to normalize individual bodies, scholars and activists developed "social models of disability" which showed that disability was not a feature of individual bodies, but rather a formation of social relations. In these models, bodies are made disabled by inaccessible public spaces, social stigma, legal exclusion, and economic inequality (Adams et al. 2015, 2).[28]

From this "social" perspective, disability is an axis of oppression that is reproduced under conditions of unequal distribution of power and resources, like race and gender. People are categorized into groups based on their different ways of moving, sensing, thinking, and communicating, similarly to how differences in the appearance of bodies are gendered and racialized. As Simi Linton writes:

> Disability studies takes for its subject matter not simply the variations that exist in human behavior, appearance, functioning, sensory acuity, and cognitive processing but, more crucially, the meaning we make of those variations (Linton 1998, 2).

Social models of disability denaturalize and destabilize dominant meanings assigned to human variation. They do so, for instance, from materialist perspectives that focus on oppression, discrimination, and economic inequality, including by challenging assumptions that disabled people cannot work (e.g. Longmore 2003), and through critical analysis of linguistic and visual rhetorics of representations of disabled people (Garland-Thomson 2000). Theorizing disability as a social construction reveals that systemic valuation and devaluation of certain ways of moving

[28] In contemporary rehabilitation medicine, the neat dichotomy between these two ways of conceptualizing disability falls apart because rehabilitation is a medical practice. Below, I give an ethnographic example showing that individual doctors are trained in, and promote, social models of disability; however, they are still doctors and their tools still organize their work around individual bodies. Thus, efforts to promote independence and self-determination might still occur by changing a disabled person's body, through surgery or therapy, or by changing their immediate environment by installing a ramp or technology-enabled Smart Homes, for example (see Serlin 2015).

or communicating are not natural or inevitable, but grounded in power; this is a critically important intervention for advocating for civil rights and justice. However, one danger of theorizing disability as socially constructed is that it can convey a sense that disability is infinitely malleable. Some theorists posit that models of disability as socially constructed erase the lived corporeal experiences of pain and do not account for embodied ontologies (e.g. Siebers [2008]2013). I discuss these theories of complex embodiment in the next chapter. For now, I focus on the insight that disability is not fixed in bodies, but rather is a dynamic social process. Destabilizing relationships between bodily impairments and social categories of disability, as disability scholars do, provides insight into clinical contexts characterized by uncertainty by demonstrating that the meaning of symptoms is contingent.

Anthropologists who have analyzed uncertainty in medical contexts show that uncertainty is productive, and can have therapeutic value. As Alice Street points out, hospitals are not laboratories; clinical work rarely reaches moments of "epistemic closure" (Street 2011, 817). In many clinical settings, including the under-resourced hospital Street studies, "uncertainty is so perpetual as to become banal" (Street 2011, 817). Uncertainty is also productive. It prompts debate and creativity among clinicians and can be harnessed to do therapeutic work. Young's analysis of PTSD shows that rearranging the temporal relationship between the past and present can constitute effective medical treatment (Young 1995). In another example, Paul Browdin demonstrates that uncertainty creates a space in which community psychiatric workers can entertain ethical debates about their interventions in people's lives. In a case he describes, clinicians genuinely disagree over a client's level of disability and capacity to live independently. In this case, "clinical uncertainty is an essential ingredient for open ethical debates over housing. It divided the team and hence made it possible to imagine alternative courses of action and to

interrogate the stakes of each potential decision" (Brodwin 2013, 111). In another example of productive uncertainty, Street describes an under-resourced hospital in Papua New Guinea, a clinical setting in which diagnostic uncertainty is not rendered problematic (Street 2011; 2014). Street uses the term "not-knowing" to "denote the more positive values and intentionalities that inhere in practices of mundane and routinized uncertainty" (Street 2011, 818). In this clinical context, two kinds of persons are made: "generally sick patients" and "distributed expert doctors," and the value attached to both revolves around the fact that maintaining uncertainty "[multiplies] pragmatic pathways" that are available for treatment (Street 2011, 831).

Together, insights from disability studies and the medical anthropology of clinical uncertainty show that possibilities for interpretation and action emerge from destabilizing the presumed relationships between what people experience and the meaning of that experience. Below, I show how VA doctors weaken the association between combat-related events and veterans' symptoms, demonstrating how productive uncertainty works in the TBI Clinic.

ARE WE HELPING OR HURTING?

A few months into my fieldwork, I was speaking with one of the TBI Clinic's therapists, Elizabeth Meigs. Elizabeth was a speech-language pathologist; she worked with veterans on improving study skills, memory strategies, and getting them technology (such as iPhones) to make school and work more accessible. Her office was windowless and somewhat cramped, but otherwise welcoming. She had fruit and granola bars on her desk for veterans, and souvenirs from academic conferences in rehabilitation. I sat next to a bookshelf holding rehabilitation textbooks, medical journals, VA-issued manuals, and many of the same books about the post-war experiences of military veterans that lined my own bookshelves. I explained my research, and

told Elizabeth that I wanted to interview patients of the TBI Clinic. Specifically, I said I wanted to understand the perspectives of "veterans with mild TBI."

Across the desk from me, Elizabeth leaned back in her chair. I had said something wrong. I assumed she was uncomfortable being asked to participate in my research, but that was not the issue. Elizabeth said she would be glad to be involved in my research and she would pass my invitation along to veterans. However, she said, when she talked to veterans about why I was in the clinic, she would not tell them that I wanted to talk to "veterans *with* mild TBI." In her work, she encouraged veterans to understand that a mild TBI is *an historical event*, not an ongoing condition. This is not to say that doctors do not accept that head injuries may have lasting consequences; I never saw a VA doctor question a veteran's headaches, irritability, or memory deficits—only the extent to which concussions from several years ago could be the most likely cause of those symptoms. In subsequent months of observation at the TBI Clinic, I learned that all the clinicians' preferred language was "veterans with personal histories of" head trauma, concussion, or mild TBI.

The clinicians' cautious and precise language— "veterans with histories of mild TBI"—flags a couple of layers of meaning. First, the phrase distinguishes between "brain injury" and "concussion/mild TBI." As with their methods of eliciting "good stories" (Chapter Four), the clinicians' precise language was standardized. According to VA's *Clinical Practice Guidelines for Management of Concussion/mild Traumatic Brain Injury*:

> The terms concussion and mTBI can be used interchangeably. The use of the term concussion […] may be preferred when communicating with the patient, indicating a transient condition, avoiding the use of the terms "brain damage" or

> "brain injury" that may inadvertently reinforce misperceptions of symptoms or insecurities about recovery (US Department of Veterans Affairs/DoD 2009, 8).

The proposition that "concussion" underscores the transience of cognitive impairments is related to the second layer of meaning flagged by Elizabeth's insistence on the phrase "veterans with a history of mild TBI." The clinicians' preferred language distinguishes between *past injuries* and current impairments. Someone "with a history of mild TBI"—like someone with a history of a broken arm—does not necessarily experience problems stemming from that injury and need not have "insecurities about recovery." This second layer of meaning is not fully incorporated into the VA's Clinical Practice Guidelines in 2009, when the document still refers to "mild TBI patients" in some places, but by 2016, the Clinical Practice Guidelines conveyed a message similar to Elizabeth's:

> Patients should not be referred to as "mTBI patients" or "patients with mTBI" as this implies that the mTBI (the injury itself, clinically defined only by immediate symptoms/signs at the time of injury) is continuing currently (US Department of Veterans Affairs 2016a, 22).

VA clinicians' adoption of this change is crucial to the way they foster uncertainty as a therapeutic technique, which I describe below. Their language positions the event of the injury firmly in the past. Above, I referenced Young's analysis of PTSD (1995) as an example of psychiatrists attempting to limit the way a past trauma recurs in the present. Another example of these concerns about how past traumas reverberate through the present is sociologist Paige Sweet's analysis of victims of domestic violence (Sweet 2014). Sweet shows that diagnostic documentation can have the effect of transforming violent events into chronic conditions that make an assaulted body into "a set of potentialities" for future un-wellness and increased risk of

health problems (Sweet 2014, 49). When this happens, bodies are "temporally extended" such that no part of the victim's present or future body is left untouched by the reverberations of the traumatic event (Sweet 2014, 48). In such cases, doctors are working to validate women's experiences, but their work has the additional effect of permanently installing a traumatic event *in the body* where it becomes constitutive of a person's sense of self (Sweet 2014, 46).

This kind of permanent reverberation of past events in veterans' present lives is what Elizabeth and her colleagues want to avoid, and I quickly learned to use their language, referring to "veterans with histories of mild TBI." But language was not their only concern. During this same early conversation with Elizabeth, I asked if there was anything she might be interested in learning from having an anthropologist around the clinic. Her answer surprised me. She told me that she would be interested in knowing if the TBI Clinic was harmful to the veterans it served. She wondered, "With our supportive services [at the clinic], are we helping or hurting [veterans]?"

I was puzzled. I asked, "How could the clinic be hurting veterans?" Instead of answering my question right away, Elizabeth sifted through a stack of papers on her desk until she located a photocopied article and handed it to me. It was a peer-reviewed article published in a medical journal and it had apparently had been circulating around the TBI Clinic. The authors' critiques of the VA's methods had prompted Elizabeth's question to me.

The article was a case report, written by clinicians in Elizabeth's field who have extensive experience with the VA (Roth and Spencer 2013). The paper describes the case of a combat veteran whose circumstances were quite different from the veterans who participated in my research. This veteran sustained serious injuries from his second tour in Iraq and was treated at Walter Reed National Military Medical Center. He recovered from his injuries, was medically

retired from the military, and he entered the VA Healthcare System for treatment of his continuing symptoms, which included persistent pain related to his injuries and chronic headaches. As per the Congressionally-mandated protocol, VA staff screened this veteran for a history of TBI and repeatedly evaluated him at a TBI Clinic like the one where I did field research. After he became a patient of the TBI Clinic, the man's medical record documented that he had developed a "heavy investment in his symptoms and diagnostic status" (Roth and Spencer 2013, 3). The authors interpret this veteran's experience as a case that "highlights critical concerns for how the diagnosis of mild TBI is considered and managed within the VA [Healthcare System]" (ibid). To blame for the veteran's decline, the doctors suggest, was "the perceived saliency of TBI as a *primary and exclusive explanation* for cognitive complaints" and "the contribution of repeat TBI evaluation in fostering iatrogenic disability" (ibid, emphasis added).

Iatrogenic illness is caused by medical examination or treatment—usually it refers to communicable diseases or infection in hospitals, re-traumatization, or physician error. In this case, the concern was not literal physical harm, but rather, that veterans would develop subject positions that made them think they were unwell, or permanently injured. In other words, clinicians worried that veterans would think they were *impaired* by their histories of mild TBI. Further, the risk that veterans would perceive themselves as impaired was obviously not related to uncontained pathogens and adverse drug effects, but rather to their encounters with the VA's data-collection efforts. The doctors' concerns revolved around what they imagined would be unintended harmful consequences of their *own attention* in the context of the VA's TBI protocols.

Elizabeth's concerns were echoed by Mara Danzig, the neuropsychologist, who told me about a veteran who had been at the clinic before my time there—a veteran whose story was similar to the case reported by Roth and Spencer (2013). Mara and the other doctors who had evaluated the veteran agreed that yes, he had had a TBI. He was doing well at the time of the evaluation and did not need the clinic's services. However, months later, and after consulting a neurologist outside of the VA, the veteran came back to the clinic and appeared to be suddenly "disabled," Mara said. She implied that the outside neurologist was not aware of these terminological nuances, had put too much emphasis on the past head injury, and over-endorsed its relationship to the veteran's present experiences. Mara explained,

> Our worry is—what's the iatrogenic effect of telling somebody that they have a bad brain? I mean, if you take away that possibility that they're going to do well, do they suddenly see themselves as a disabled person?

When these doctors express anxiety about veterans taking on disabled subjectivities, they are not worried that veterans will claim disability as a political identity and harness the transgressive power of words like "crip" (Linton 1998). When people refer to themselves as disabled, they intentionally highlight disabled people as a political group that is devalued and discriminated against, and they draw attention to a perspective that is silenced (Linton 1998, 13). Rather, the doctors were reproducing a problematic link between disabled people and the inability to achieve things. By pointing this out, I am not suggesting that the VA doctors believed that disabled people are necessarily incapable. Rather, they were trained to question the relationship between a person's way of moving, communicating, and thinking, and the meanings of differences in a social context. For instance, one resident physiatrist explained that he was taught to distinguish

conceptually between disability and impairment early in his medical training. This is how he described the difference:

> An impairment is a lack of a certain physiologic function, like my ability to close my hand tightly, let's say. And then a disability is the manifestation of that within society. Impairments aren't necessarily disabling.

This doctor's distinction between an impairment and a disability comes from the academic field of disability studies. Separating the properties of a body (impairment) from their social meaning (disability) is the theoretical mechanism by which the social model of disability works. In theoretical terms, impairment "signifies physical or biological lack (a missing arm, the experience of blindness)" (Ralph 2015, 107). The meaning of impairments is structured entirely by a social process "that converts a perceived deficiency into an obstacle" (Ralph 2015, 107). In distinguishing between impairment and disability, this young doctor follows what some in disability studies call for—a focus on what is outside the body, "the social, political, and intellectual contingencies that shape meaning and behavior" (Linton 1998, 6).

In the theoretical terms of academic disability studies, Elizabeth and Mara worried that a medical encounter would prompt someone to suddenly begin seeing themselves as *impaired*. This is how a therapist like Elizabeth came to worry that the TBI Clinic is hurting veterans. The clinicians did not tell veterans that they "have a bad brain," of course. But what Mara points to (and what Roth and Spencer [2013] point to as well) is that the whole procedure communicates to veterans that something is wrong with them. In this sense, the elaborate process of getting veterans to the clinic and documenting their past head injuries in effect amounted to "telling somebody that they have a bad brain." From the clinicians' perspective, TBI Clinic itself might be a harmful environment precisely because it is organized around clinical attention to mild TBI.

HAZARDS OF DISCOVERY

Recall the VA neuropsychologist who compared the VA's TBI Clinical Reminder and Screening Tool to a fishing net. His metaphor is so apt because it describes the process of screening OEF/OIF veterans for exposure to mild TBI (the screen is cast like a net over a whole population), and it also suggests that like industrial fishing, the process is not harmless. As I discussed above, clinicians saw ways that veterans' encounters with the "net" might be dangerous. Although the screening process was effective at moving veterans around the VA, the doctor observed, it may have been designed a bit overzealously. Describing the effects of the screening and referral process, he said:

> I liken it to bycatch. [When you are] basically throwing out a huge fishing net, you get some tuna in there. And you get some boots. And you get some non-saleable fish. We [in the TBI Clinic] get everything when we ask, "Have you ever had any memory problems? Have you ever been hit on your head?" I think the net was thrown a little too quickly and a little too widely, I guess.

The screening procedure did "catch" veterans who needed specialized care. But it also brought other veterans to the clinic as "bycatch." Doctors worried that clinical attention directed where it was not really required might be harming these other veterans who were scooped up in the VA's net. Thus, the bycatch metaphor depicts some clinicians' concerns about participating in this system of knowledge-production about mild TBI. The metaphor of the net and its bycatch illustrates the tensions that arise when there is an imperative to reconcile research and care. The clinicians working at Western's TBI Clinic have institutional obligations to the VA's larger data-production efforts and clinical obligations as caregivers. On an abstract level, these obligations are not incompatible: learning about how mild TBI affects people is part of caring for the

population of veterans (cf. Jain 2013). However, in practice, the two tasks pulled doctors' attention in different directions.

VA doctors' conflicting responsibilities are a feature of working in an institution, comparable to other institutional dilemmas such as the "impossible mandate" of providing adequate psychiatric treatment, in an emergency unit, in a limited time frame (Rhodes 1991, 1). These dilemmas are exemplary of the social space of the institution and therefore they cannot be resolved with the application of the right perspective (Rhodes 1991, 8). But precisely because of this, they are also instructive. In particular, they reveal the dilemmas of "making up people" (Hacking 2006).

In his study of the social sciences, psychology, psychiatry, and clinical medicine, philosopher Ian Hacking has coined two phrases to describe what happens when people are made the objects of scientific inquiry: "making up people" and "looping effects." In Hacking's terms, "making up people" refers to the way that new scientific classifications—such as multiple personality disorder (Hacking 1995)—bring new kinds of people into being (Hacking 2006, 2). Hacking's "looping effect" names the dynamic process through which people and categories are mutually productive. "Kinds" of people are brought into being by being classified and when they interact with the classifications, the interaction shapes the people and the efforts to classify them:

> They are moving targets because our investigations interact with the targets themselves, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved (Hacking 2006, 2).

The two processes—making up people and looping—operate together as what Hacking calls "dynamic nominalism," which involves not only classifications and the people they classify, but also institutions, knowledge, and experts (Hacking 2006, 5). Making mild TBI into a "signature

injury" of war is a process of dynamic nominalism. The TBI Clinical Reminder, the TBI Registry, clinicians, and veterans are part of the web of people, processes, and categories that Hacking describes. Whether the "kind" of people that emerges from this process is called "veterans with mild TBI" or "veterans with histories of mild TBI" matters to VA clinicians—it matters because it effects their options for intervention.

To make mild TBI visible and populate the national TBI Registry, doctors elicited veterans' stories of traumatic events (Chapter Four). They carefully collected details about the event to achieve a certain degree of confidence in making a retroactive diagnosis of concussion, and in the process of performing this institutionally-mandated attention to mild TBI, they necessarily foregrounded explosions, mortar attacks, motor vehicle accidents, and other events. As I discussed above, doctors' concerns about the effects of this mandated foregrounding of traumatic events revolved around how they might reverberate in veterans' present lives and conceptions of their impairments. In the remainder of the chapter, I show how doctors temper the effects of this mandated attention to events by allowing events to subsequently disappear from clinical interactions. To treat veterans with histories of mild TBI, doctors transform the monolithic and ill-defined "mild TBI" into a constellation of symptoms that can be addressed individually. In the place of traumatic events, mundane, ostensibly non-traumatic aspects of everyday life (both in the military and after the military) are incorporated into clinical explanations for veterans' cognitive difficulties.

EXPANDING THE ETIOLOGY OF VETERANS' ATTENTION PROBLEMS

Given that they worried about veterans being harmed by their clinic, how do doctors prevent veterans from taking on a biomedical and personal identity in which the mild TBI is a

permanent impairment? They intervene to weaken the causal link between the injury and the symptoms by focusing on all the different things that might cause impaired cognition. Again, the doctors did not dismiss veterans' array of cognitive deficits, only the extent to which those symptoms could be said to come from a years-old concussion. They emphasized that cognitive deficits come from many causes, including insomnia, pain, alcohol and drug use, depression, and post-traumatic stress disorder (cf. Hoge and Castro 2014; Hoge et al. 2008; Verfaellie et al. 2012).

In nearly all cases, doctors in the TBI Clinic dealt with what they call non-specific symptoms—symptoms that do not indicate (and are not specific to) any single disease. As part of their intake paperwork, veterans visiting the clinic complete an "inventory" of their symptoms (called the Neurobehavioral Symptom Inventory [NSI]; see King et al. 2012). The inventory includes twenty-two symptoms, ranging from experiences like dizziness, nausea, and numbness to "symptoms" that many people would experience regularly and not attribute to any illness: lapses in concentration, forgetfulness, trouble making decisions, difficulty thinking, fatigue, irritability, and frustration. Veterans who are evaluated for histories of mild TBI are asked to report these symptoms because researchers find that compared to veterans without histories of TBI, veterans with histories of TBI experience these twenty-two symptoms more severely, but they also reported anxiety disorders, depression, and PTSD, suggesting that "probable PTSD and other affective concerns are a significant factor in reports of postconcussive symptoms in veterans with a documented history of TBI" (King et al. 2012, 886). In other words, the symptoms are not necessarily caused by a mild TBI, which means they are probably caused by other things. This is the space of productive uncertainty in which the doctors operate.

On the one hand, that veterans' symptoms could come from any number of things was part of the danger. As one doctor put it, concisely, "People can attribute everything to TBI." She explained:

> When people begin to focus [on the idea] that they've had permanent brain damage they start to attach or attribute all sorts of other symptoms—normal, stress-related symptoms, PTSD, depression, whatever—to the TBI.

At the same time, because symptoms like headaches, insomnia, attention and memory problems can be caused by many things, they can also be addressed from many different angles.

The doctors' strategy, explained here by a neuropsychologist, was to treat veterans' symptoms while also stressing that the symptoms did not necessarily mean they had permanent brain damage. This is a strategy of expanding the etiology of the symptoms.

> We address the functional deficits. So even though you might not know what's going on, if a patient is having sleep problems, you make sure that they're getting help for their sleep, or their anger management, or their substance abuse. You have to just tackle those separate issues. That's what I tell the veteran. I'm honest. I say, "We don't know how much of this is your brain injury and how much of this is your depression or your PTSD."

This was Dr. Jo Hart, a young, academically-accomplished doctor with experience in sports neurology. Her office was in an old building on the north side of the Western VA's campus. The office was roomy enough to accommodate a large round table, where we sat one afternoon under the sun streaming in through the window. The wire mesh embedded in the glass indicated the building's age.

Jo's account shows how "not-knowing" (Street 2011) works to open new possible avenues for intervention. She "might not know what's going on," but she can offer help for sleep, anger management, and substance abuse. However, "not-knowing" is itself important in this context because it provides a counternarrative to the message that veterans have "brain damage." Jo mentions that she is upfront with veterans about her not-knowing, and she explains her approach to working in a context where she really could not provide a definitive answer as to what was causing veterans' cognitive problems.

> The vast majority of people we see are truly distressed. They are experiencing some things and trying to communicate that. So the trick becomes not to dismiss those symptoms, but also not to reify the head injury.

Jo has extensive training in neurological anatomy and was drawn to the specialty because of a fascination with how the brain works. However, Jo explained, she would not talk to a veteran about the neuropathological processes that so fascinated her, such as changes in ion balances in the brain when it is concussed. If she did that, she feared, veterans might get focused on the idea that their brain had been permanently damaged, and consequently, they would get "stuck on the TBI." She said:

> It's important to educate people about other things that can effect cognitive functioning. Because otherwise people get stuck on the TBI and they consider themselves permanently damaged—permanently disabled. [And that] really doesn't do anyone any good. You know, people who [were] high-functioning in the military get caught up in this new picture of themselves as incompetent, unable to do things, and that's just usually not accurate… My concern [is]…

> having [someone think] [she gasps] oh my god, *traumatic brain injury*.
>
> *Permanent damage*!

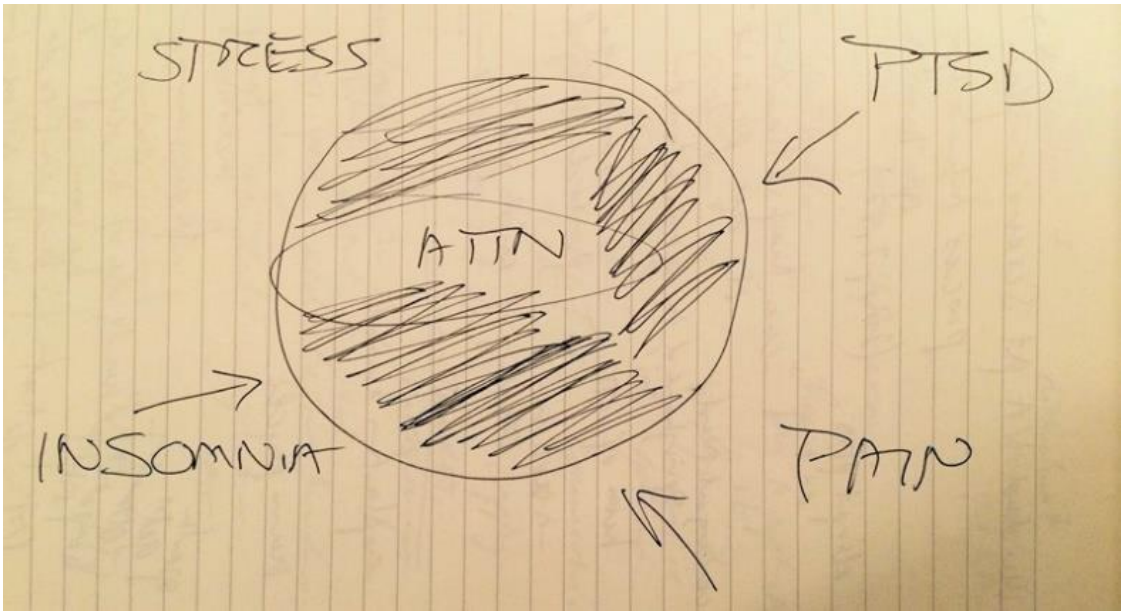
In the hopes that veterans do not "get caught up in this new picture of themselves as incompetent," the doctors avoided the futile effort to pinpoint a single cause of the symptoms (which they cannot do), and they avoided talking about neuropathology. Instead, they talked about "not-knowing," and they focused on treating symptoms. Jo said:

> The VA focus has very much been on symptom reduction. Treat what you can. In that sense, I think we're doing the right thing. We know they've got cognitive problems and we know they've got really bad depression and pain. We've got these great treatments for depression. We've got these good treatments for pain. Let's get rid of those and see if their cognitive problems go away.

Jo showed me how she explained this to veterans. "You think of attention as a circle," she said.

In my notebook, Jo drew a circle. The circle represented the scope of a person's attention. "Attention," she told veterans, was a mental process of restricting your focus to specific things within your field of perception.

"What is the vet struggling with? PTSD. And that definitely takes up some attention." Scribbling with long straight lines, she shaded the inside of part of the circle, segmenting off about a quarter of it.



Neuropsychologist's diagram of an expanded etiology for attention deficits.
Photograph by the author.

"What else is the vet struggling with? Pain. That also takes some attention."

She filled another portion of the circle with ink.

"What else is the vet struggling with? Lack of sleep. So that also takes up some attention." She scribbled more. The circle filled up with blocks of scribbled ink. Jo labeled each block of attention that was being consumed by the different factors she named: "PTSD", "pain", and "insomnia."

"What else is the vet struggling with? Daily stress." She scribbled more. "Stress in the marriage. Stress with the kids. Stress adjusting back to civilian life. Just daily stress, which eats up our attention as well."

After the attention devoted to all this everyday stress was used up, a very small patch of blank space remained in the center of the circle.

"So, by the time we're done," Jo said, "that's what the circle looks like." Jo labeled the small remaining space "Attention." This small space represents the available cognitive capacity a veteran has to pay attention to all the things they often say they have lost the ability to remember: grocery lists, doctors' appointments, the dry cleaning, schoolwork, and so on.

"That's the attention they have left," Jo said in a resigned tone, and sighed.

Jo presented attention as a finite resource that was being consumed by a variety of different physiological, psychological, and social problems. Her explanation was convincing, and some time later, I saw how it worked when I was out to lunch with one of Jo's patients.

I was having lunch with Robbie Navarro—the Marine whose medical records demonstrated that he was "connected" to the VA. We met at a Mediterranean diner called "Kabab Express." Robbie had chosen the restaurant. He liked their chicken shawarma, and it was close to both of our apartments. We ordered at the counter in the dark interior of the place, and Robbie chatted familiarly with the staff. After we ordered, we retraced our steps through the front door and settled into a booth on the patio, which was shielded from the sun by a dark green canvas awning. A tall hedge gave the illusion of also being shielded from the traffic on the main road.

Robbie was in a graduate program in social work, and our conversations frequently came back to his experiences in school. This year, he had taken a semester off to try to get his cognitive symptoms under control. It frustrated him to perform poorly in school.

"The TBI and the PTSD affect your ability to concentrate," Robbie told me. "For example, the fact that you're wearing your sunglasses is making me much more comfortable."

"Why?" I asked.

"Because I can see behind me in the reflection," Robbie said. "If you're not concentrating on what's behind you or around you, you can focus better on class, or other things. Everything is a distraction, pretty much. If someone drops something, or is looking at their phone..."

Robbie trailed off—distracted—because the waiter came to our table with our sandwiches.

"Thanks, man," Robbie said.

Following Jo's model, Robbie could not focus on class because his PTSD-related symptoms and other distractions—like something dropped, or the waiter arriving with food—consumed most of his attention. He had adopted the model of attention that he had learned from Jo in the clinic. However, it seemed that Jo and Robbie may have felt differently about the reflection that Robbie could see in my sunglasses. "If you're not concentrating on what's behind you," Robbie said, "you can focus better on class." Jo would agree with this: Robbie's inability to focus on class was not because of permanent damage to his brain, but because he was only paying attention to what was around him. But, Robbie said that it made him feel *better* to know what was behind him—when he *knew* what was behind him, then he was less distracted and could focus. Robbie's head injuries were part of what was behind him, but they were something he could not really know about. Jo and the other doctors could not show him—with any certainty, at least—what the effects of those injuries might be. And in fact, the doctors seemed to be trying to take away the reflective surface by encouraging Robbie to not look back. In this sense, the kind of uncertainty the doctors were comfortable with seems not to match up with the kind of uncertainty veterans were comfortable with.

Conclusion

Disability scholars destabilize categories of normalcy. Although war and disabled veterans were central to the formation of rehabilitation medicine (Linker 2011), understanding American military veterans' experiences through the lens of Disability Studies is fraught. Not only is the military an institution that perpetuates categories of normalcy, but for military veterans, disability can be configured quite different from how others experience it. Whereas scholars and activists have applied theories of disability to struggles for civil rights and social equity for disabled people who have historically been denied such necessities, disabled members of the United States military enjoy a status of exceptionalism, idealized as symbols of patriotism and strength. Further, disabled veterans often do not adopt identities as disabled people. As historian David Gerber writes, veterans who "become disabled well into an adult life of conventional able-bodied functioning, or on the cusp of adulthood anticipating such a life […] embrace conventional roles and identities" (Gerber 2012, xiii; see also Açıksöz 2012).

Despite veterans' unique position as a disabled group, I have drawn from literature on disability to make two arguments: first, that rehabilitation clinicians distinguish between symptoms, impairments, and disability, and second, that the clinicians' therapeutic efforts intervene in the space of productive uncertainty between impairment and disability. I have shown in this chapter that VA doctors work to keep veterans from becoming "stuck on the TBI." They are cautious about the effects of their own mandated clinical attention to mild TBI. They use language that places traumatic events firmly in the past, and try to limit how those events reverberate in veterans' present lives. They "expand the etiology" of veterans' symptoms in efforts to prevent veterans from becoming convinced that they are permanently impaired. In all of these activities, doctors emphasize their "not-knowing" so as to not reify a causal relationship

between past events and veterans' present cognitive problems. In Hacking's (2006) terms, though they are part of the engine of discovery operating around the "signature injury," they work to prevent the "making up" of "veterans with mild TBI."

CHAPTER 6. THINKING ABOUT THINKING

> A body is docile that may be subjected, used, transformed and improved.
>
> Foucault [1977]1995, 136

> In this emerging neuro-ontology, the claim is not that human beings *are brains*. The argument is different – that our selves are shaped by our brains but can also shape those brains.
>
> Rose and Abi-Rached 2013, 16

The veterans whose experiences I have discussed throughout this dissertation are cultivating post-military lives. For many of them, this involves using the educational benefit of the Post-9/11 GI Bill, which provides tuition, books, and stipend payments for living expenses. In the years during which I conducted this research (2011 and 2015), the number of veterans using Post-9/11 GI Bill benefits increased from 555,329 in 2011 to 790,507 in 2015. Eighty-four percent of recipients of VA education benefits in 2015 were using the Post-9/11 GI Bill. More than half of the VA education benefits paid out that year were to veterans who were earning

Bachelor's degrees, and three quarters of those veterans earning Bachelor's degrees were paying for them using the post-9/11 GI Bill (US Department of Veterans Affairs 2016b).

However, veterans at the TBI Clinic found that their efforts in higher education were impeded by nonspecific cognitive and emotional symptoms like forgetting everyday tasks, irritability, and difficulty learning. Above (particularly in Chapter Two), I described an explanation for veterans' cognitive impairments that circulates among veterans and clinicians in the TBI Clinic: the "transition" out of the military can make everyday aspects of post-military life difficult. The social aspects of the "transition" are also incorporated into the expanded etiology for veterans' symptoms that VA clinicians propose (Chapter Five).

Above (Chapter Two), I showed that doctors, social workers, and anthropologists have used the concept of "transition" to highlights the very real difficulties that physiological and psychological trauma obscure: adjusting to disrupted mundane routines, being separated from friends and co-workers, and beginning a new career. The utility of the concept is that it shows how veterans' lives have been interrupted. Here, I complicate the "transition" concept by showing how its emphasis on interruption affects veterans with histories of mild TBI. Some veterans attributed their post-military problems not only to interruptions in their social and professional lives, but interruptions in their *consciousness* caused by mild TBI. When veterans focus on a physiological interruption, it undermines clinicians' efforts to "expand the etiology" of their symptoms. In this chapter, I discuss clinicians' introduction of a counternarrative to the disruption implied in "transition."

As a therapeutic intervention, clinicians proposed a sense of *continuity* in veterans' lives. I arrive at my interpretation of clinicians' therapeutic efforts as a "counternarrative" by way of theories of disability. Specifically, I draw on Rosemarie Garland-Thomson's concept of

"misfitting" to explore some of the ways VA clinicians and veterans use themes of interruption, continuity, and context to make sense of mild TBI as a physical injury with cognitive effects.

The specific ethnographic example I analyze is a clinical situation where veterans learn to "think about thinking." This is a unique VA program in which veterans learn about their brains' cognitive processes. Though the program was held in a clinical setting, it mimicked a college classroom, complete with a syllabus, reading assignments, and weekly lectures about mental processes, such as attention and memory. I argue that this program aims to cultivate among veterans a sense of embodied continuity, and that it locates this continuity *in the brain,* which is somewhat surprising for a clinic organized around brain injury.

EMBODIED MINDS

Disability scholars show that disability is socially constructed, but that does not mean that bodies are infinitely malleable or that they do not matter. Disability is produced by the effects of disabling environments, but it is also produced by chronic pain and the effects of aging and illness—factors that "derive from the body" (Siebers [2008]2013, 290). Disability scholar Tobin Siebers theorizes the body and its environment (including representations) as reciprocal and mutually transformative; this is called complex embodiment. Theories of complex embodiment are indebted to feminist philosophers who "have long argued that all knowledge is situated, that it adheres in social locations, that it is embodied" (Siebers [2008]2013, 288, citing Haraway 1991 and Harding 1986). Knowledge is situated because it is based on perspective *and* embodiment. Siebers writes, "the presence of the body does not boil down only to perspective but to profound ideas and significant theories about the world" (Siebers [2008]2013, 289).

Critical disability studies scholar Rosemarie Garland-Thomson proposes a model that helps explain how disability is complexly embodied. She proposes that a "dynamic encounter between flesh and world" results in a "fit" or a "misfit" (Garland-Thomson 2011, 592). When bodies and their environments "fit" together, the encounter reinforces nondisabled privilege and normativity. Garland-Thomson writes:

> Fitting occurs when a generic body enters a generic world, a world conceptualized, designed, and built in anticipation of bodies considered in the dominant perspective as uniform, standard, majority bodies (2011, 595).

With "fit" comes the ease of movement and anonymity that are privileges enjoyed by people with normative bodies, normative communication styles, and normative cognition. In Garland-Thomson's terms, when veterans were in the military, their bodies "fit" the institutional space in which they operated. The situation of misfitting, by contrast, describes a disjuncture between body and an environment: "a square peg in a round hole" (Garland-Thomson 2011, 593). Both the "peg" and the "hole" take on meaning in the awkward encounter between them, and in this sense, "misfitting" illustrates the reciprocal and mutually transformative relationships between bodies and their environment observed by Siebers ([2008]2013). But what happens when the "flesh" that encounters the world is the brain?

In a feminist analysis of neurobiological bodies, Victoria Pitts-Taylor applies misfitting to the embodied mind. Theories of the embodied mind, Pitts-Taylor argues, "must pay attention to discrepancies and dissonances in how minded bodies and worlds fit together" (Pitts-Taylor 2016, 46). Pitts-Taylor analyses cognition as a bodily experience, highlighting the mind's embeddedness in its social and physical environment. Pitts-Taylor's analysis shows that knowing and thinking are spatially and temporally specific, embodied events (Pitts-Taylor 2016, 65).

As theories of complex embodiment pertain to veterans, knowing and thinking are embodied experiences; their embodied experiences and situated knowledge includes their military experience. Anthropologists who study militaries and veterans show that war and military service produce certain kinds of bodies. The soldier's body is the archetypal docile body, shaped by the archetypal disciplinary institution—the military (Foucault [1977]1995). Soldiers' bodies are simultaneously targets—and weapons—they are turned into tools that meet the needs of the US Army (MacLeish 2012, 55). Once soldiers' bodies have been shaped to meet the institution's needs, it is not easy to reverse the transformation. For instance, Seth Messinger shows that the military's overwhelming emphasis on physical functioning and athleticism remains foregrounded, even after soldiers have been grievously injured, and American military rehabilitation is organized around the identity of "tactical athlete" to such a great extent that other possible subjectivities are eclipsed (Messinger 2010a; 2010b; 2014). Brigitte Sørensen notes a similar phenomenon among Dutch veterans with limb-loss who strive to maintain an athletic body as an extension of their military past (Sørensen 2015). These transformations in service members' bodies are among the "combat-connected transformations" observed by Zoë Wool, who also documents how soldiers' everyday physical movements—activities as mundane as walking down the street—evidence their embodiment of military ways of being and moving (2015). When people leave the military and resume life in civilian communities, embodied traces of their military training may cause problems, as for example, when veterans startle too easily in response to everyday disturbances (Messinger 2013). In these instances, veterans' bodies sit uneasily in their environment. Following Garland-Thomson (2011) and Pitts-Taylor (2016), I extend these observations to veterans' embodied minds, and I interpret veterans' cognition as "misfitting," in Garland-Thomson's terms.

VETERANS' PHYSIOLOGICAL EXPLANATIONS FOR THEIR IMPAIRMENTS

In their examination of the "neurological turn," Nikolas Rose and Joelle Abi-Rached (2013) name neural plasticity as pivotal in contemporary techniques of government. The art of government, as discussed by Foucault in his 1978 lectures, is an exercise of power "that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument" (Foucault 2007, 108). Neural plasticity refers to the discovery that adult brains continue to grow new nerve cells, and that this neurogenesis "might be stimulated or inhibited by environmental factors from nutrition to cognitive activity" (Rose and Abi-Rached 2013, 12). Situating the brain in its environment like this provided an "opportunity to explore the myriad ways in which the milieu got 'under the skin,' implying an openness of these molecular processes of the brain to biography, sociality, and culture" (Rose and Abi-Rached 2013, 52). As a result, "the plastic brain itself became thinkable as open to government by experts. It simultaneously became open to action by each individual themselves" (Rose and Abi-Rached 2013, 52).

For instance, the mind and brain sciences became a technique of governmentality that structures how individuals act upon themselves and relate to others (Rose and Abi-Rached 2013). This shift toward brain-based, neurobiological conceptions of the self has been critiqued as dangerously individualist (e.g. Martin 2000), but Rose and Abi-Rached argue that we do not need to concede that we *are* our brains to see that the somatic ethic is "gradually extending from the body to the embodied mind—the brain" (Rose and Abi-Rached 2013, 22). According to Rose, the neurosciences shift our conceptions of ourselves from psychological individuals to somatic individuals. What Rose calls "somatic individuality" is "the tendency to define key aspects of one's individuality in bodily terms" (Rose 2003, 54). This is the sociocultural context

in which veterans experience mild TBI as a physical injury to the mind. When these veterans attribute memory loss and disorientation to the physical trauma of brain injury, they locate the source of problems in their bodies, and specifically, in their brains. They interpret their experiences from the subject position of being somatic individuals.

The veterans whose experiences I discuss here are concerned about changes in their brains. They come to the VA for help with cognitive impairments—problems with memory, communication, and mood. In interpreting their cognitive impairments, some veterans take on a kind of "somatic individuality" (Rose 2003), locating the problem inside their bodies, and assuming that something must be wrong with their brains. For instance, one veteran conveyed the physicality of this injury when he compared the blast to being hit by a train:

> When you're rattled by an IED, the blast—it's the shaking. It feels like you got hit by a freight train. Everything inside hurts, but there's no external damage.
>
> – Thirty-year-old male Marine Corps veteran, in 2014

The veteran's description of the sensations of "shaking" and the "hurt" leave no doubt that he experienced the explosion as a physical injury, although there was no trace of it on his body. Another veteran, injured when a detonated bomb slammed him into the ceiling of his vehicle, drew a direct causal relationship between his injury and his subsequent memory problems. He believed that his brain function had changed:

> I think your brain probably doesn't function the same way it used to function and that's why I've got some memory loss and sometimes I'm just disoriented in space. It doesn't happen that often, but for maybe five minutes, I'm looking around and thinking, "Where am I? What am I doing here?"
>
> – Thirty-four-year-old male Army veteran, in 2015

In these veterans' descriptions, the brain is a fragile organ, vulnerable to shaking, hitting, and malfunctioning after physical impact. They emphasize the physicality of the impact, although its mark on the body is invisible to the eye and medical imaging technologies. With TBI, sociologists Daniel Morrison and Monica Casper write, "the visual cues so common to physical disabilities are absent, making TBI seem more like [a mental illness] rather than an acute bodily injury—despite the harrowing materiality of the initial incidents and the cascading nature of brain damage and degeneration" (Morrison and Casper 2012, unpaginated).

Mild TBI is an invisible physical injury that has mental consequences. For instance, one veteran explained that he knew he had a "problem with [his] mind" because routine events—like visiting a friend's house—were just missing from his memory:

> My wife will say, "Oh you remember we went and did this?" It's just not there. Anything about it. It's… weird. I just don't have any recollection of certain events, at all.

He explained that the uncertainty around his memory problems bothers him:

> If your knee hurts or your back hurts—that's a lot easier to understand and to rationalize. But when you have a problem with your mind, it's kind of scary. I mean, if you forget every experience you ever had, you wouldn't be you anymore.
>
> – Thirty-two-year-old male Marine Corps Veteran, in 2014

These veterans demonstrate how TBI resists neat classification as either a psychological or physiological problem, and their experiences are consistent with Rose and Abi-Rached's argument that the Cartesian mind/body dualism has come to seem anachronistic. With the onslaught of research and popular literature that features visual renderings of neurons, synapses,

and parts of the brain, "the brain has entered popular culture, and mind seems visible in the brain itself" (Rose and Abi-Rached 2013, 5).

What is the TBI Clinic to do considering the coexistence of two explanations—one that traces cognitive impairments to injuries, as I have described here, and one that traces them to transitioning out of the military (Chapter Two)? The clinicians cannot cure an injured brain, and the purview of mainstream medicine does not include military reform. In the next section, I show that the TBI Clinic's Cognitive Skills for College Program advocates that veterans approach their cognitive difficulties from a position akin to "misfitting" (Garland-Thomson 2011). The Cognitive Skills for College Program brings veterans' attention to their bodies—and specifically, their brains—but challenges the idea that there has been a physiological disruption in their cognitive abilities. Instead, it posits that the disruption has been in their environments, in which they now "misfit."

THINKING ABOUT THINKING

During my fieldwork, I observed three cycles of the Cognitive Skills for College Program, co-designed and taught by Elizabeth and the other speech-language pathologists. The class met for two hours, once a week, over six weeks. The "classroom" was the windowless, carpeted conference room of the TBI Clinic, in which the furniture had been rearranged into rows of tables and chairs facing a single table positioned in the middle of the front of the room. A slide presentation was projected from Elizabeth's silver laptop to two side-by-side, wall-mounted flat-screen TVs.

Veterans attended the class because they struggled to succeed in higher education; they were using federal Post-9/11 Veterans Educational Assistance benefits (known as the GI Bill) to

pursue degrees from trade and professional schools, community colleges, and four-year colleges and universities. Veterans worried that their cognitive abilities had changed because of their combat-related TBIs, as discussed above. One veteran, thirty years old at the time, experienced a cognitive problem that might be called aphasia—difficultly finding words. He described it as "losing words." He was pursuing a Master of Social Work; in conversations with colleagues he stuttered and felt unable to hold a cohesive train of thought. In an interview, he said:

> I'm losing my words. I'm having a hard time picking up on new information. I used to be a very eloquent speaker and now I just feel like—for lack of a better word—I feel stupid. I should be able to get out my thoughts. I don't pick things up as quickly. How that's different from ADD [attention-deficit disorder], I don't know. Maybe it's not.

Comparing his experience to ADD, this veteran pointed out the difficulty of distinguishing between cognitive problems, an aspect of mild cognitive impairment that frustrates veterans and clinicians. Another veteran avoided the matter of causality entirely when he said succinctly: "I listen in class, but I can't absorb the knowledge." These nonspecific cognitive impairments—trouble concentrating and processing new information, trouble finding words, an inability to "absorb the knowledge"—were the problems the TBI Clinic's classes sought to help veterans understand and manage.

The Cognitive Skills for College Program was an exercise in metacognition, or developing an awareness of one's thinking and learning processes. Clinicians called this "thinking about thinking." In addition to practicing thinking about thinking, veterans also embodied the role of college students. They were given a syllabus, reading and writing

assignments, quizzes, and they listened to (quite dry and technical) lectures on cognitive processes including attention, memory, and problem solving.

On a Friday morning, I sat in the TBI Clinic's conference room. It would be the first class meeting of a new cycle of the Cognitive Skills for College Program. Elizabeth led six veterans into the conference room; they all walked into the room, without using prosthetic limbs, canes, or wheelchairs. Their t-shirts and cargo shorts revealed no visible burns or scars. Elizabeth had placed black plastic binders on the tables. They sat, and began thumbing through the binders. Elizabeth was casually dressed in jeans and a loose blouse, and she lifted herself onto the table next to the computer table, where she sat with her legs crossed at the ankles and leaned toward the group, gripping the edge of the table. From her perch, under the fluorescent lights, Elizabeth broke the ice by asking the veterans to tell her about their experiences in school. As in any classroom, on the first day, the "students" were slow to respond—no one spoke.

"Other students in your classes," she said expectantly, "do they distract you?"

One veteran said, "Yeah, by talking to each other, and looking at Facebook."

The others nodded in affirmation.

Another veteran, now animated, offered, "They're [the students are] redirecting the conversation on tangents, going on for too long about their own interests. If a staff sergeant is talking, you're not going to talk over them!"

Elizabeth tapped the computer to advance the slide presentation. It was clear that she had predicted the veterans' complaints because the next slide read:

> *Irritability may make it difficult for you to tolerate others' behavior because it does not align with military standards of conduct.*

In the TBI Clinic, "irritability" was an emotional problem most veterans complained about. Since returning from deployments overseas, they were angry and impatient; they often wanted doctors to help them be more patient with their families. Clinicians like Elizabeth called veterans' anger and impatience "irritability," and considered it a nonspecific symptom with many possible causes: PTSD, insomnia, overuse of alcohol, and so on. With her initial question— "Do other students distract you?"—Elizabeth prompted the veterans to notice their own irritability and how it shaped their experiences in the classroom. In the military, they learned (and were required) to behave with deference toward people in authority. In college, their civilian classmates failed to treat the instructors with the reverence superiors would receive in the military. Though another student might be able to ignore these common classroom annoyances and focus on what the professor said, these veterans could not. They were distracted.

The veterans' problems with their classmates essentially revolved around the classroom being *not* the military. Elizabeth's pedagogy centered on the military—the social context in which veterans' minded bodies once "fit." Again, following Pitts-Taylor, when we see knowing and thinking as spatially and temporally specific to one's environment (Pitts-Taylor 2016, 65) we can understand that veterans' cognitive capacities might differ from the military context to the higher education context, regardless of what had happened to their brains in the meantime. Cognitive habits that are disabling in a classroom context were perhaps not disabling in the military. And to recall Garland-Thomson's observation that disability is produced in the dynamic encounter between minded bodies and their social environments, we can see that the meaning of irritability and distraction shift, depending on the context: "[w]hen the spatial and temporal context shifts, so does the fit, and with it, meanings and consequences" (Garland-Thomson 2011, 593). In other words, not being able to "absorb the knowledge" in class due to distracting

classmates may be evidence of a cognitive impairment. However, it may also be an expected part of the transition from military life to college life. Elizabeth's focus on the *encounter* between veterans' bodies and their classroom environment complicates both framings.

During the next meeting the following week, habits of military life were a central topic again. Keeping to the task of encouraging metacognition, Elizabeth facilitated a discussion among the veterans about their military training, thus moving their embodied knowledge and habitual ways of thinking into the realm of their conscious attention.

Fifty minutes into the second meeting, the veterans yawned and stretched and tapped their pens, looking bored. Elizabeth was as energetic as always, but the combination of the slide presentation and her singsongy cadence seemed to be lulling everyone to sleep. Then, Elizabeth advanced the presentation to a slide with a bulleted list. It was an outline of how we make decisions, she said:

Comparing the new task to more familiar ones;

Developing a plan;

Implementing the plan;

Evaluating the plan relative to the outcomes;

Modifying the plan as needed.

Encountering this list, the veterans sat up straighter and were more engaged. This list resembled an Operations Order (an "OPORD" in military acronymic speech), or a field order. Elizabeth smiled at their recognition, and said, "I've been told that this slide is almost identical to what's presented in boot camp."

The veterans erupted in a chorus of affirmations. This was a part of military life they knew well. The problem-solving framework had a different form and different acronym in each military branch, so Elizabeth called on someone.

"What's the Marine's acronym for that?" she asked.

"BAMCIS," the Marine veteran responded (pronounced "bam-sis"). Reflexively, he recited, "Begin planning. Arrange for reconnaissance. Make reconnaissance. Complete the plan. Issue the order. Supervise."

An Army veteran sitting one row in front of the Marine offered his version: "We use the five paragraphs of the Operations Order to plan missions. The first paragraph is Situation. The second paragraph is Mission. Execution. Command and signal. Service and support."

A Navy veteran added: "The Navy doesn't plan missions, just prioritizing and carry them out. But you have to assess the resources and figure out what is most important to do, in what order."

Elizabeth pulled them away from their branch-specific military jargon and offered a wide-angle view of the field order's relevance, saying, "[In the military,] you go over tactical situations, and learn automatic ways to solve problems because there is no time to sit and think about it. They give you mental models to store in your head, so when you encounter a situation, you can just—BAM! —rely on it. They're not just telling you to go out and figure it out all on your own."

In Elizabeth's interpretation, the field order was a "mental model," etched in the brain. Indeed, the extent to which this way of thinking had become habitual for the veterans was evidenced by their quick recall of military tactical planning jargon, although many had been out of the military for years. By walking them through this exercise, Elizabeth demonstrated the

productive power of the military as an institution, and that their military habits were still in their bodies. She substantiated her point by comparing thinking habits with a very material, physical habit.

Elizabeth asked the veterans, “How many times did you clean your weapon every day?”

“Two hours a day,” someone answered.

“And how easy did it become for you after a year?”

They nodded, and mumbled.

“Yeah, I could do it in my sleep.”

“Easy.”

Elizabeth said, “It’s about taking something complex and breaking it down so it’s more intuitive. It’s painful to do the first few times, but then you get it. What we want you to learn here is a strategy, or framework.”

Cleaning a semi-automatic weapon is a complex task that the veterans had learned to do in discrete steps, and with practice. After some time, it became an embodied skill. Likewise, military tactical problem-solving is a complex task, for which the veterans had been provided with problem-solving models. In the military, they learned both physical and cognitive habits quickly and thoroughly; practicing them was enforced. As Elizabeth said, “[the military is] not just telling you to go out and figure it out all on your own.”

Now these veterans were confronted with new situations, but she proposed that they had strategies and frameworks to deal with them. How to write a paper for a college class? Where is a good place to study? How can I establish good relations with a professor? These were problems that it seemed they did have to figure out all on their own, but Elizabeth began to show them that they were already in possession of models for doing these things.

Walking between the tables, Elizabeth asked, “What are the steps used in planning and executing a military mission that are also used when solving everyday problems?”

The veterans continued to respond with characteristic military brevity, but they were no longer repeating memorized processes. They were actively engaged in translating the military models for action.

Speaking slowly, one veteran offered, “Assess the situation. Collect and gather resources. Set goals.”

Elizabeth praised this response, and asked for more ideas.

“Recon. Supervising,” another veteran answered.

This veteran had not translated sufficiently. Elizabeth probed, “Can you tell me what ‘recon’ means?”

“Make a plan, and go check and make sure the plan is gonna work.”

Eventually, Elizabeth helped the veterans distill this military jargon down to the “civilian” version that she wanted them to remember:

Goal

Plan

Do

Review.

Elizabeth asked the veterans to switch from receiving and executing instructions to reflexively paying attention to their cognition—thinking about thinking. She was rather straightforwardly suggesting that they engage in what Rose and Abi-Rached call “brain awareness,” a technique that somatic individuals use in the name of self-improvement and maximizing our well-being (Rose and Abi-Rached 2013, 22).

For her final example of applying the steps used in military missions that are also used when solving everyday problems, Elizabeth asked the veterans to consider how they could apply a "mental model" to a problem that was perhaps very unfamiliar to some of these young men. She asked, "Can you use this structure to plan a five-year-old's birthday party?"

Immediately, one veteran asked, "Is it a boy or a girl?"

They talked through the steps, laughing about the example but taking the exercise seriously, pushing each other to be more specific in their imaginary birthday party "Operations Order." They came up with:

Asking the kid what she likes;

Asking afterwards if she had fun;

Reviewing to see how they'd do it differently for her sixth birthday party.

When they finished the exercise, Elizabeth said with compassion, "These skills may have saved your lives. In another scenario, they can help you do well in class, or avoid a fight with a loved one."

The takeaway, in Elizabeth's framing, was that they should recognize that their military training was applicable to their current educational and familial responsibilities, including things as mundane (but important) as writing term papers and planning children's birthday parties.

Elizabeth's Cognitive Skills for College Program brought veterans' military pasts into the present and deconstructed the habits they took for granted, which I interpret as an effort to establish a kind of embodied continuity. Veterans' minded bodies were disciplined by the military's array of enforced habits, processes, and problem-solving procedures. Those physiological and cognitive habits had not disappeared, and the "misfitting" veterans experienced in civilian life proved that. The first two frames for veterans' experiences – injury

and social disruption – both foreground the experience of interruption. Elizabeth's therapeutic move in the Cognitive Skills for College Program carved out an alternative space that allowed for a military-minded body to exist in a new civilian context, without ignoring veterans' disabilities.

Conclusion

With the rise of the new brain sciences over the past fifty years, humans are understood increasingly in neuromolecular terms; techniques such as mindfulness and metacognition have joined other techniques of governmentality that operate in liberal democratic societies (Rose and Abi-Rached 2013). But as Foucault reminds us, government of populations does not replace the disciplinary power of institutions, and in fact, government depends on discipline (Foucault 2007, 107). Foucault writes: "[m]anaging the population does not mean just managing the collective mass of phenomenon or managing them simply at the level of their overall results; managing the population means managing it in depth, in all its fine points and details" (Foucault 2007, 107). As the brain—or the embodied mind—becomes a more and more prominent target for judgement, evaluation, improvement, inquiries into the art of government should account for the role of disciplinary institutions. Insights from Critical Disability Studies show that disability is produced in dynamic encounters between bodies and their environments. Theorized as a dynamic encounter, disability is neither a characteristic of an individual body, nor a set of exclusionary practices or linguistic conventions. Rather, disability occurs to *bodies in context*, and institutions are part of that context. Insofar as disability, fitting, and misfitting show us something about both bodies and social environments, people's movements between institutions—like veterans'

movements from the military, to school, and the VA—are particularly fertile ground for understanding how institutions produce minded bodies (Pitts-Taylor 2016), and to what effect.

In this chapter, I have drawn on Garland-Thompson's ideas about disability and "fit" to interpret the Western VA's Cognitive Skills for College Program as a clinical setting that offers veterans with histories of mild TBI a vision of themselves as people who experience a "misfit" between their minded bodies and the civilian contexts in which they now live and work. My analysis of that program as promoting a kind of embodied continuity emerged in comparing it to other ways of understanding veterans' post-military cognitive problems as the result of physiological brain injury and the social disruptions that come with leaving the military. The proposition of embodied continuity that emerges from the Cognitive Skills for College Program may have therapeutic value for some veterans, but more broadly, it highlights how disciplinary institutions become part of our bodies and our conceptions of disability.

As a final observation about institutions and cognitive impairments, I note that these veterans' way of thinking—and their trouble adjusting to post-military pursuits like higher education—are not human variation that has occurred through genetics, illness, or accident. Their minded bodies and their injuries occurred by design. As historian David Gerber writes:

> Disability and disfigurement are not incidental to war's purposes nor marginal to its effects, but rather, alongside the murder of those killed, the point to begin with. Only in making victims can war achieve its political ends (Gerber 2012, 4).

When they entered the military, these veterans' bodies were not disabled. Due to injuries, or a misfit between their disciplined bodies and their social milieu, they were disabled upon exiting the military, which reminds us that an examination of disability and institutions also needs to attend to the fact that some institutions are, in fact, actively disabling.

CONCLUSIONS

In this dissertation, I have argued that the TBI Clinic at the Western VA is shaped by intersecting forms of power that characterize contemporary life. In doing so, I follow anthropologists who show that hospitals exist in dynamic relation with the society in which they operate (Rhodes 1991; Street 2011) and ethnographers of institutions who show that contradictions and paradoxes are part of institutional life (Brodwin 2013; MacLeish 2013; Rhodes 2004; Wool 2015). The VA is assigned significant responsibility for what happens to people after they leave the military: veterans' physical, psychological, and vocational rehabilitation are integral to the endurance of militaristic fantasies of wars without casualties. Yet, the VA has little authority to contain or discipline veterans, who are no longer subject to the totalizing disciplinary power of the military. Thus, the VA exercises—and clinicians and veterans become subject to—the more fluid, flexible forms of power described as "control" (Deleuze 1991). In the VA, soldiers' docile bodies are transformed into the tracked and targeted bodies of civilians.

An irony of individual freedom is that any departure from an established pattern of movement "ends up being automatically signaled as suspicious" (Chamayou 2014, sec. 12). Following this insight, I have conceptualized the VA's screening procedures as technologies that provoke movement, while still noting that in an institutional setting, these technologies only

work as modes of control and targeting if clinicians' attention is disciplined to meet the institution's needs, for example, by directing their attention to gaps and interruptions in veterans' "connection" to the institution.

Underlying these projects of screening and movement is mild TBI's status as a "signature wound" of the wars, and I draw on ethnographic data to expand our collective understanding of the category of the "signature injury" and the work it does. The "signature injury" has symbolic and discursive power derived from the way it connects wounding technologies and healing technologies as dual ways in which bodies are marked by war. The category of "signature injury" also guides institutional practice by rendering mild TBI problematic in a way that makes it the basis for conducting the conduct of individuals (Miller and Rose 2008, 14).

In my fieldwork at the Western VA, I observed doctors navigating uncertain biomedical terrain and institutional paradoxes, and I looked to scholarship in anthropology, the sociology of health and illness, and Disability Studies, to provide context for my observations. My work intervenes primarily in two ongoing conversations in contemporary anthropology. First, to studies of the American military, service members, veterans, and their communities, this project contributes an ethnographic account of combat-related mild TBI in the post-9/11 era. To my knowledge, it is the only ethnographic study of the VA's interventions around combat-related mild TBI, and it is one of few ethnographies of the VA Health Care System (see also: Finley 2011; Hooyer 2015). One of my central observations about the VA is that although it is organized as a health care system, its interventions are not limited by the boundaries of biomedicine. As other scholars studying the American military, service members, and veterans show, decentering trauma and moving away from biomedical conceptions of the effects of war brings a much-needed holistic perspective on war and its effects, and allows for critiques of

militarism and military power (Hautzinger and Scandlyn 2014; MacLeish 2013; Wool 2015). My perspective on veterans' experiences has been shaped by these studies, and by bringing these insights back to a clinical context, I show that they are helpful for understanding the VA's uniqueness as a clinical context that "treats" problems associated with veterans' transitions out of the military. At the same time, attending to the limits of medicalized interpretations of veterans' problems in a clinical setting puts my research in conversation with the work of other anthropologists who are interested in demedicalization, more broadly, and the intersections of medical and non-medical settings (e.g. Yates-Doerr and Carney 2016; Wentzell 2013).

Second, this project contributes to the anthropology of institutions an ethnographic account of how ideological commitments take shape in everyday practice. I have situated my observations about mild TBI in the larger context of fantasies of about war and trauma, including recuperative fantasies (Stevens 2011), rehabilitative fantasies (Linker 2011), and war without casualties (Chamayou 2015). Connecting everyday operations at the VA to the larger social and historical processes that those operations help produce provides a culturally-contextualized way of understanding the ends of government (Rose et al. 2006). The institutional paradoxes of the TBI Clinic reveal the VA to be an institution that manages populations at two scales: clinicians provide medical care directed at individuals, but their work also entails the production of knowledge that is aimed at an entire generation of OEF/OIF veterans. Further, as Didier Fassin writes, institutional action is produced at the intersection of the local and the national, and therefore, "institutions allow for the theoretically delicate and methodologically uncertain operation of interconnecting the macro-sociological and micro-sociological levels, a problem long faced by the social sciences" (Fassin 2015, 7). By situating the action of the TBI Clinic in fantasies of war without causalities, I have suggested a way that we might connect the VA—

ostensibly a civilian health care system—to anthropologists' observations about larger national and international projects of war and militarism (Gusterson 2007; Lutz 2002; Vine 2015).

MAJOR FINDINGS

In this dissertation, I describe practices related to the production of knowledge about veterans' histories of mild TBI, and the effects of those processes for veterans and clinicians. I also describe and analyze the therapeutic strategies that VA clinicians use in this clinical context. My findings provide ethnographic evidence of how the TBI Clinical Reminder and Screening Tool and the national TBI Registry work, and they highlight the paradoxes and contradictions inherent in each.

First, VA protocols like the TBI Clinical Reminder and Screening Tool are designed to move veterans to the TBI Clinic, and they achieve this goal. However, my research suggests that the movement the protocols initiate is not without consequences. From the perspective of some VA clinicians, the screening protocol appears to operate as a "net." Cast widely, it risks bringing too many veterans into the TBI Clinic for evaluation. On the one hand, bringing veterans into the TBI Clinic allows clinicians to assess and cultivate veterans' "connection" to the VA. On the other hand, clinicians worry that their own clinical attention to past injuries may harm veterans by causing them to draw unsupported and unnecessary conclusions that their persistent cognitive and emotional symptoms are related to permanent impairments.

Second, I describe the process that VA rehabilitation specialists use to retroactively diagnose mild TBI. Following the procedures outlined in VA's *Clinical Practice Guidelines* and the protocol for populating the National Veterans TBI Registry, doctors conduct lengthy verbal evaluations of veterans' past injuries. This is a process that departs from traditional clinical

practice in one significant way: because mild TBI is invisible in veterans' bodies so many years after their injuries, doctors' attention is directed at objects (such as military vehicles) and collateral information (such as other people's experiences), rather than at veterans' bodies. As such, veterans' role in the clinical encounter is not to present their bodies for examination, but rather, to offer their memories to be filed in a national database. Overall, this project demonstrates that the VA's efforts to deal with the unique needs of an entire generation of veterans conflict with—and sometimes undermine—doctor's efforts to pay clinical attention to the needs of individual veterans whom they meet in VA exam rooms.

These major findings are connected by a single theme: attention. This dissertation is about veterans themselves, who have trouble paying attention. It is also about institutional attention, by which I mean the various ways that these veterans capture (and are captured by) the attention of the institution charged with their care, the VA. When we think about institutions—such as schools, hospitals, and government agencies—we often see the ways in which they pay too much or too little attention to the people who encounter them. For instance, when people struggle to get the attention they need from health care systems and welfare bureaucracies, we could say that these institutions are not paying enough attention to the people they are established to serve. Likewise, help for asylum-seekers is tied to their ability to capture the attention of those who represent the state (Fassin 2012). Just as often, people receive too much attention from institutions, and what comes to mind here is the disproportionate attention that black Americans and Latinx Americans receive from the police. Both too little attention and too much attention from institutions can be dangerous—even deadly.

The veterans whose experiences I have described are often not actively seeking medical care, nor are they being shrugged off by an institution that dismisses their problems. Thus, my

exploration has centered on processes that sit in between these two familiar poles of too little and too much attention, as well as on the consequences of paying attention to populations in the abstract. As a society, we call on institutions like the VA to provide resources, care, education, discipline (and so on) for groups of people, to learn about problems that affect those populations, and to take some action to address them. But in the TBI Clinic, the scales intersect in complicated ways, as veterans who engage with the VA—and the doctors who treat them—are continuously brought into the larger institutional project of generating information about the abstract population of post-9/11 veterans to which these individuals ostensibly belong. This raises larger questions not only about what happens to military veterans, and who is responsible for it, but a much broader question about what happens to people when they encounter institutions that are set up to pay attention not to individuals, but to abstract groups of people.

Future directions for anthropological research

My research points to several directions for future ethnographic research to expand on these themes and questions. Veterans' reported experiences clearly indicate that leaving the military is a challenge, but one of the limitations of this project is that I spoke with veterans months (or years) after they exited the military. More research is needed to understand the nuances of veterans' exits from the military and what prompts them to begin using VA services. Since 1991, the Department of Defense and its service branches have had in place versions of a program currently known as the Transition Assistance Program. This is a brief, formal training program that service members complete before they leave the military. DoD and VA employees counsel veterans about their benefits, including employment and relocation assistance, educational opportunities, health and life insurance, and educate them about financial planning,

writing resumes, and job search skills. Despite documented improvements to the military's transition program in recent years, its effectiveness seems to be limited by its brevity, and by the fact that veterans complete the training in the weeks before they are released from their military contracts. Veterans' memories of their participation in these programs suggest that they were excited, distracted, and generally unconcerned with finding work immediately. Ethnographic research about this formal program and its impact on veterans' experiences would generate useful insights about this period of "transition."

Further, clinicians' experiences indicate that the VA is uniquely equipped with resources that may mitigate the challenges associated with this transition. For example, VA social workers' and nurses' "clinical relentlessness" constitutes a level of individual attention that would be impossible in many health care settings, and the VA's institutional support for such activities as the Cognitive Skills for College Program indicates an unusual degree of flexibility and scope beyond traditional biomedicine. Thus, more research is needed to understand the VA's capacities and roles as an institution that provides more than health care. Specifically, an anthropological perspective would provide insight about how the VA's institutional model could be relevant to the needs of other groups of people, beyond veterans.

Finally, the veterans and clinicians who participated in this project suggest that from many angles, the meaning and experience of mild TBI is profoundly shaped by anticipation of what the future will hold for people who have been exposed to multiple head injuries, and particularly blast-related head injuries. At the same time, the therapeutic practices that I describe in this dissertation are grounded in this very uncertainty and carried out by clinicians who emphasize "not-knowing" (Street 2011). How will therapeutic practices evolve as medical knowledge about the effects of mild TBI changes? Will doctors one day look back at this period

in the history of the formation of knowledge about mild TBI and, as one VA neuropsychologist predicts, "realize [they] told everybody the wrong thing?" How will veterans' impressions of their injuries and subsequent experiences change as they age? Will mild TBI and this period in its history come to symbolize another period of neglect and scandal? Just as all previous modern wars have had "signature injuries," so too will future wars—and as with mild traumatic brain injuries, we will look to them as we try to understand the policies, politics, and ideologies that govern war and institutions.

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VITA

Anna Zogas received a B.A. from the University of Michigan in 2004 and an M.A. from the University of Chicago in 2008.