

NAVY MEDICINE

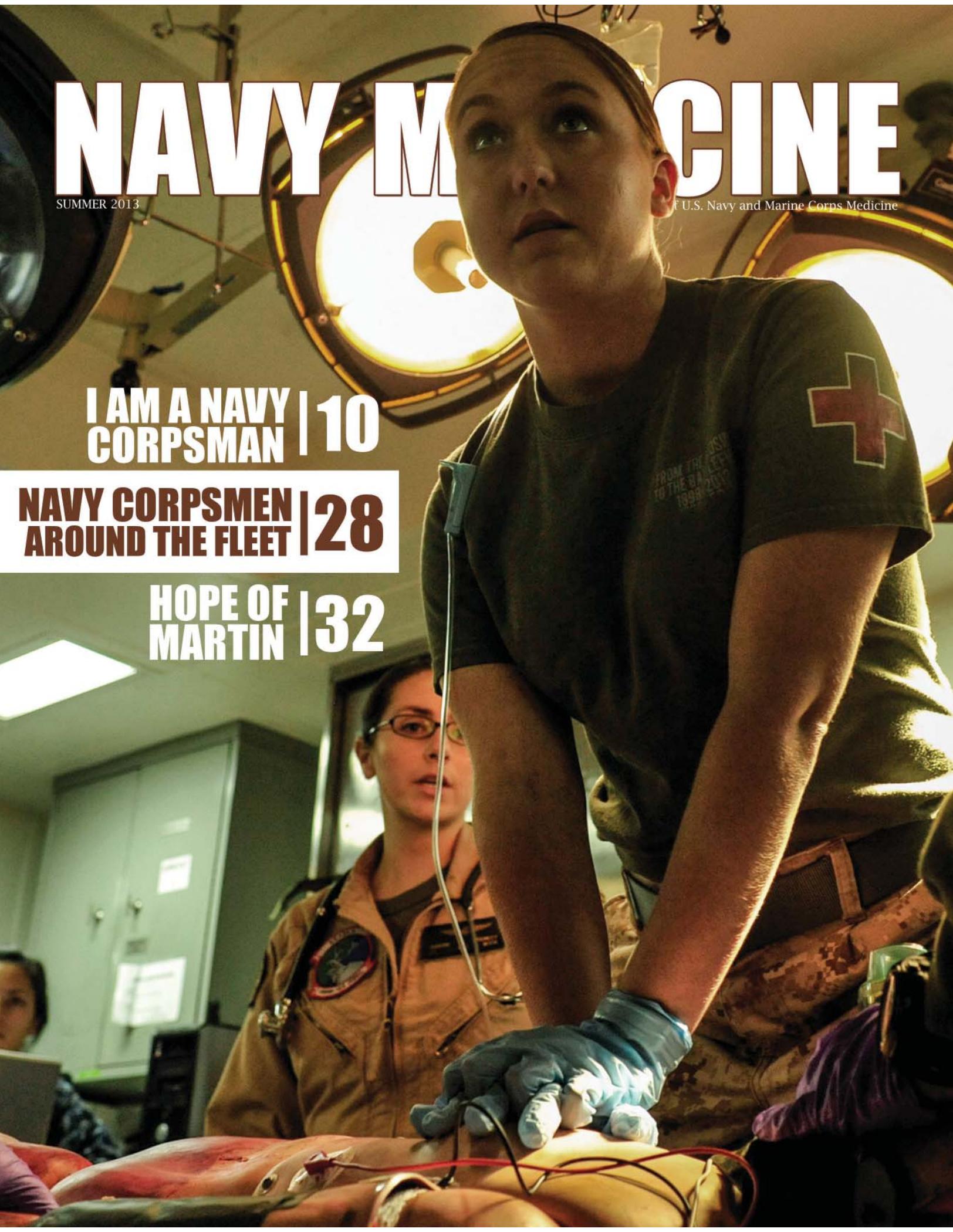
SUMMER 2013

U.S. Navy and Marine Corps Medicine

**I AM A NAVY
CORPSMAN | 10**

**NAVY CORPSMEN
AROUND THE FLEET | 28**

**HOPE OF
MARTIN | 32**



NAVY MEDICINE

Official Magazine of U.S. Navy and
Marine Corps Medicine

Vol. 105 • No.4 SUMMER ISSUE

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NAVY MEDICINE is the professional magazine of the Navy Medical Department community. Its purpose is to educate its readers on Navy Medicine missions and programs. This magazine will also draw upon the medical department's rich historical legacy to instill a sense of pride and professionalism among the Navy Medical Department community and to enhance reader awareness of the increasing relevance of Navy Medicine in and for our nation's defense.

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Photos must be minimum 300 dpi.

Photos showing action are preferred.

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for author. In the event there is more than one author please assign one

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Feedback Welcome

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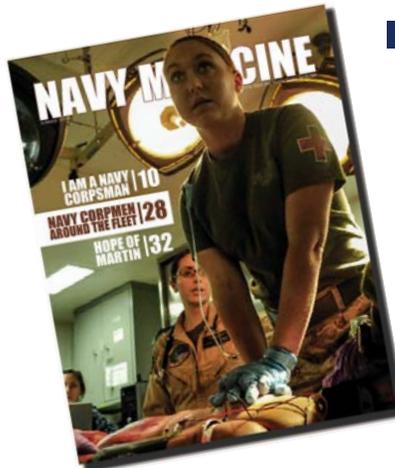
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CONTENTS

Summer Issue

- 4 | Admiral's Call
- 6 | Force Notes
- 10 | I am a Navy Corpsman
- 14 | Navy Corpsman Finally Laid to Rest
- 16 | Acupuncture: More Than Trauma Care
- 20 | Recon Doc
- 22 | Mass Casualty Drill
- 24 | Once a Chief Always a Chief
- 26 | Saving a Life
- 28 | Navy Corpsmen: Around the Fleet
- 32 | Hope of Martin
- 36 | A Day in the Life
- 42 | Sailors Train Ugandan Soldiers
- 44 | EHR Inpatient Standardization
Benefits Patients
- 46 | Things I've learned:
Rear Adm. Michael H. Mittelman
- 48 | Innovations/R&D
- 52 | A Look Back



On the Cover

Hospital Corpsman 3rd Class Briana Bartholomew, assigned to the Air Combat Element of the 13th Marine Expeditionary Unit, conducts CPR during medical training aboard the amphibious assault ship USS Boxer (LHD 4). Boxer is conducting amphibious squadron and marine expeditionary unit integrated training. (Photo by Mass Communication Specialist Seaman Apprentice Veronica Mamma)

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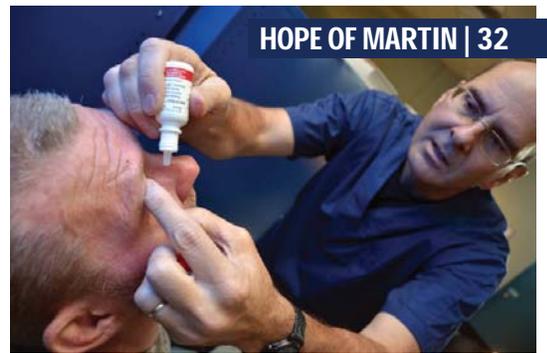
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I AM A NAVY CORPSMAN | 10



NAVY CORPSMEN: AROUND THE FLEET | 28



HOPE OF MARTIN | 32



A DAY IN THE LIFE | 36

JOINTNESS IS PARAMOUNT

Jointness is paramount as we move toward a more collaborative and plugged-in world across the Military Health System. By partnering with our sister services and other federal health care institutions, non-governmental organizations, the private sector and our academic partners, we are becoming stronger. We're building a better team together using the synergy of each of our strengths. This jointness is also pivotal to value and readiness in the care we provide and the way we execute our mission.

Whether you are a Navy researcher attached to one of our Navy Medical Research Units around the world; a corpsman in school at the Medical Education and Training Campus at Fort Sam Houston or an orthopedic surgeon at Walter Reed National Military Medical Center; your job influences all services. I would like to focus this month on the many partnerships across the enterprise in such areas such as research and development, medical education, resource sharing, and clinical informatics, among others that exemplify how

we are working in a joint environment.

Nowhere is jointness more prominent than in Navy Medicine's research and development partnerships worldwide. Many Navy Medicine researchers and labs work with local ministries of health, academic partners, and international health organizations around the globe to conduct lifesaving research. Navy Medicine has supported several research projects in the areas of psychological health, traumatic brain injury, suicide prevention, trauma medicine, disease surveillance, vaccine development, entomology, and drug testing. Some examples include the Millennium Cohort Study, which is the largest long-term health study in U.S. military history, and the Navy Drug Testing program. The work conducted at the



Navy Entomology Center of Excellence (NECE) is a great example of jointness in research and development. NECE has partnered with scientists and public health professionals from the Army and Air Force, as well as the World Health Organization, U.S. Department of Agriculture, and other federal agencies to develop new insecticides, techniques and application technologies to control blood feeding insects that transmit human disease that threaten the warfighter on the battlefield, such as malaria and dengue.

We are also seeing jointness in our education and training. A prime example of this is at the state-of-the-art joint Medical Education and Training Campus (METC) at Fort Sam Houston, Texas where our corpsmen learn alongside Air Force, Army and Coast Guard personnel. The METC offers our enlisted personnel more than 60 medical programs of instruction, and boasts 24,000 annual graduates. We are very proud of the great work that is being done there.

Navy Medicine also has a robust sharing program with the various Depart-

Our approach will be joint where possible; however, we will continue to excel and invest in those capabilities that are uniquely inherent to Navy Medicine.



University of California, Los Angeles's Operation Mend, Navy Medicine and Marine Corps leadership and staff came together to discuss shared initiatives in advancements in research and development, clinical infrastructure, and wounded warrior care at the Defense Health Headquarters. (Photo by Valerie Kremer)

ment of Veterans Affairs hospitals and clinics. Resource sharing between Navy Medicine and VA allows for enhanced services to both DOD and VA beneficiaries, while promoting cost-effective use of federal health care resources through less duplication and underuse of resources. We share services in the areas of: cardiology, physical therapy, mental health, OBGYN, surgical services, emergency services and other sub-specialty care. In addition, Navy Medicine and VA maintain clinical research relationships to gain further understanding of deployment-related injuries and illness, PTSD, impact of various military stressors, and overall health status of active duty military, guard/reserves, retirees and other veterans.

Our clinical informatics directorate at BUMED leads the tri-service effort to standardize our Essentris Inpatient Electronic Health Records (EHR). They

have been working hard to create and lead content advisory groups to best optimize and improve our inpatient Essentris EHR. Today, there are more than 900 tri-service clinicians and other key players involved in patient care who meet regularly to determine the best way to standardize Essentris inpatient content and workflows in medical treatment facilities (MTF) worldwide. As a result, our EHR now has better clinical decision support and resources, uniform workflows and potentially improves patient outcomes. Another benefit of standardization is decreased training costs. When you move to a new MTF, less orientation and training is needed because workflows are now more similar across all of our MTFs.

As I tell all who ask, we must find the efficiencies and synergies of joint care and processes. Equally important is to always celebrate those Navy traditions

and unique mission requirements that will always fall to a maritime portfolio. Our approach will be joint where possible; however, we will continue to excel and invest in those capabilities that are uniquely inherent to Navy Medicine. I have had the honor to command Army and Air Force personnel, I have practiced in the VA hospital system, and I have seen the passion that the private sector and academic centers bring to our mission united we will make a difference for the Warrior in combat and the family at our door. We will celebrate our joint accomplishments and cherish our spirited traditions (Go Navy, Beat Army!) One Team, one Fight!

I am very proud of the work you do each day. Thank you for your service and as always, it is my honor and privilege to serve as your surgeon general.

--Vice Adm. Matthew L. Nathan

Standardization Saves Lives

Standardization is more than making things the same. Standardization, especially in military health care, creates a “culture of patient safety.” The types of supplies ordered, color coded bracelets and the universal understanding of emergency code calls is needed to survive in a joint environment, and that is where we stand today. Standardization saves lives.

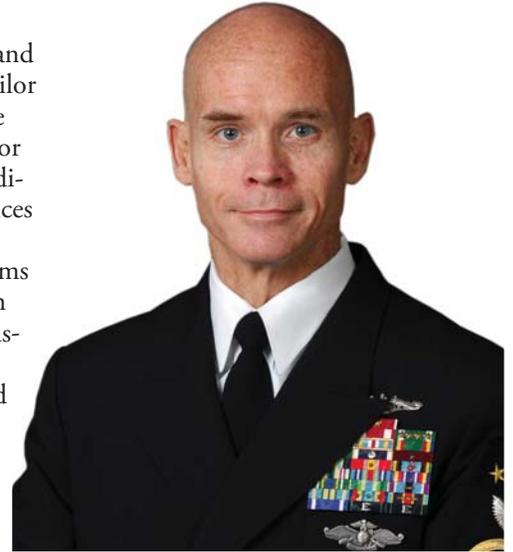
In the winter edition of Navy Medicine, I wrote an article on jointness. It’s only right to follow that article with an understanding of standardization. After more than a decade of war, our health care systems have increasingly become more joint. Fort Belvoir, Great Lakes, Walter Reed-Bethesda and even our own Medical Education Training Command (METC) are joint facilities. This puts emphasis on the phrase “One team, one fight.” Regardless of the color of your working uniform, blue, gray, or green the mission is the same. Ship, Shipmate, Self!

The Medical Health System and the Department of Defense (DoD) continue to employ standardization throughout our services. With the increase in technology, our electronic health

records, information management, financial and resource management and clinical processes have merged. A Sailor seen at an Army Hospital will receive the same care and treatment that he or she would receive within a Navy medical facility. On the horizon our services are working on the Virtual Lifetime Electronic Record (VLER), which aims to develop a standard DoD policy on sharing family member health data using a combined portfolio of health that includes benefits, personnel, and administrative information. It will provide our veterans, service members and families with a “one stop shop” for health care information and benefits.

You may hear terminology such as “Memorandums of Understanding (MOU),” or Joint Governance Processes” these phrases streamline our processes within joint environments. Closer alignment of our senior leadership, enlisted and officer, will provide the support needed to ensure higher transparency, clearer accountability and integrated capability-based management.

Our culture in the Navy is not something we want to change, but we need continue to embrace our sister services.

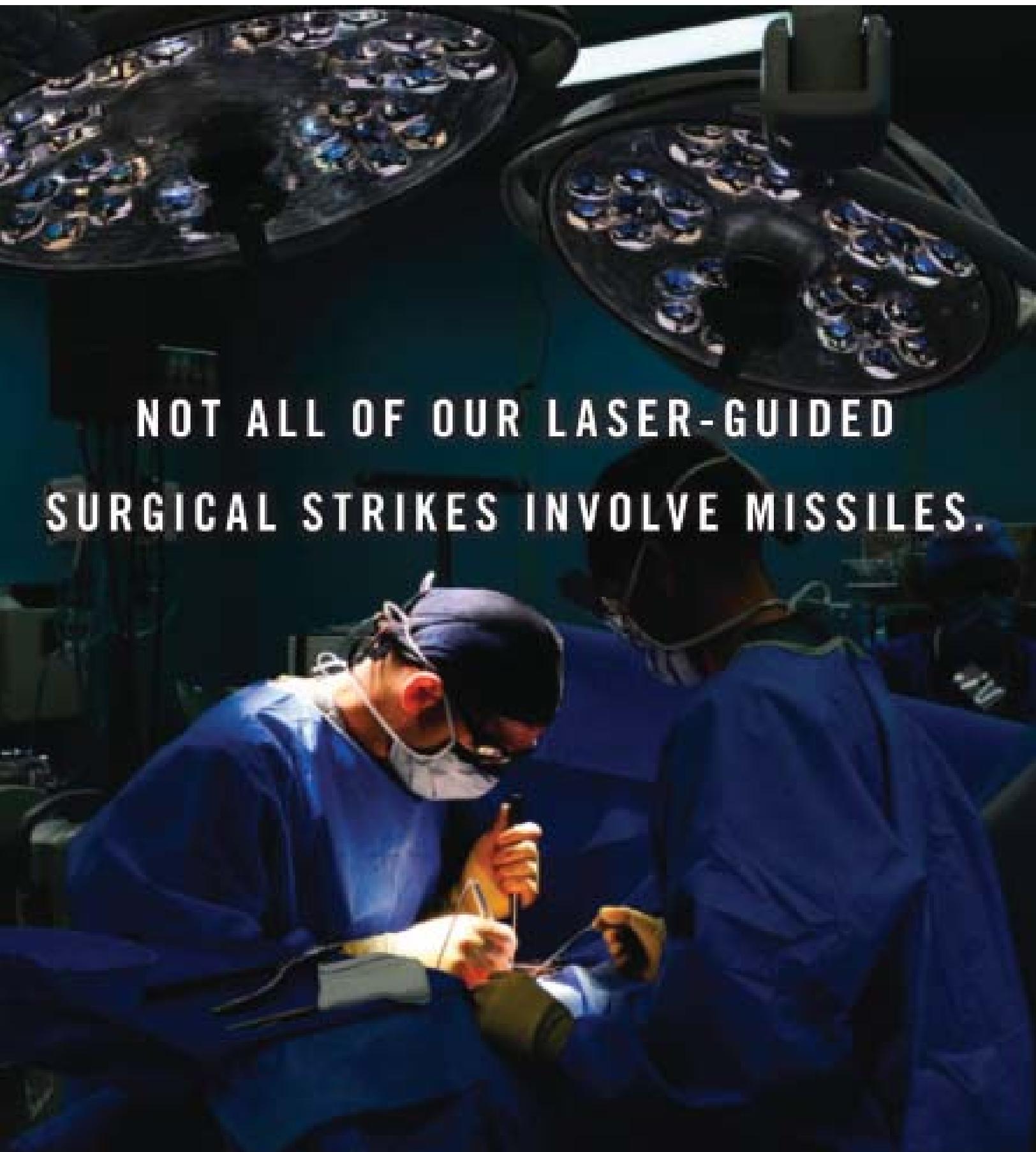


Learn from their history and experience as they continue to learn from ours. Standardization within our health care settings is a must if we are to carry out the most effective form of patient care and provide the “continuity of care” that we have prided ourselves on for so long. From the battlefield to the clinical setting, the health and welfare of our Sailors, Soldiers, Airman and Marines and their families comes first!

*-- Force Master Chief
Sherman E. Boss*

Chief Hospital Corpsman Steven White (right), Naval Medical Center Portsmouth Pharmacy department, discusses plans for the pharmacy’s upcoming renovations with U.S. Navy Bureau of Medicine and Surgery FORCE Master Chief Sherman Boss. White told Boss that the renovations will bring in robotics to assist in filling prescriptions and reconfiguring the waiting. (Photo courtesy of U.S. Navy Bureau of Medicine and Surgery)





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BATH SALTS

... IT'S A NIGHTMARE



I am a ... NAVY CORPSMAN

By Paul Ross | U.S. Navy Bureau of Medicine and Surgery Public Affairs

Editor's note: This is part two of a three-part series featuring individuals who serve as Navy hospital corpsmen.

Navy corpsmen are unique individuals within their service that deploy anywhere they are needed to provide medical care. When asked why a corpsman chose his or her career field, there is almost always a

resounding answer – to help others.

For Senior Chief Hospital Corpsman Kellie Hamilton, the call to serve was no different.

“I love to help people when they are sick,” said Hamilton, the Hospital Corps planner and action officer for the U.S. Navy Bureau of Medicine and Surgery FORCE Master Chief. “I could be at the grocery store walking down the medicine isle and I’ll hear someone ponder about what medicine to take and I’ll actually start talking to them about what

the different drug names actually mean. If you were truly sick, then I would stand up to just about anyone to ensure that you were taken care of.”

Such was the case during a 10-mile hike while the corpsman, who has more than 19 years in the career field, was stationed in Pohang, Korea.

“I had a Marine sprain his ankle and could not walk anymore,” Hamilton said. “As I directed the injured Marine to the van, I had a sergeant keep telling him to shake it off and keep moving. As

“It was their intent to burn it down, but they did not know that there were no political personnel in that building, just women and children hiding from the riot.”

- Senior Chief Hospital Corpsman Kellie Hamilton

tracks, while standing a foot shorter.

But for the corpsman, standing out as a female in mostly male-dominated deployments is something she takes great pride in. Although when she first enlisted her father was more concerned with her safety – pushing her toward a medical career.

“I don't think I really had a choice (to be anything but a corpsman),” Hamilton said. “My family steered me towards medicine. My father is a retired Navy chief signalman and he was the main reason I joined the Navy. I believe that he thought I would be safe as a corpsman and just work in hospitals. Low and behold, I haven't worked in a hospital for over 13 years.”

Throughout those years she has traveled across the world and found herself in difficult situations, including post-civil war Sierra Leone.

“That was truly expeditionary medicine at its best,” Hamilton said. “I had zero medical support and no MEDEVAC capabilities in a post-civil war type environment where tensions were the highest. I trained the medical support for the Republic of Sierra Leone Armed Forces how to do the smallest things, like take blood pressures and understand medicine.”

While training local forces in medical capabilities seems like a typical duty of a hospital corpsman, another instance while in Sierra Leone earned Hamilton a commendation for bravery from the British military.

“While I was in Sierra Leone, the election season became very heated,” said Hamilton, a native of Troutrun, Penn. “There were riots, assaults and fear of another civil war. One day, while coming back from a forward patrol, my British lieutenant colonel and I found ourselves in the middle of 500 rioting people. While I was in my vehicle, my colonel was talking with the local tribal chief, trying to calm the situation.”

The situation soon grew dire as a group of 40 men lined up with torches and began marching toward the opposing political party's building.

“It was their intent to burn it down, but they did not know that there were no political personnel in that building, just women and children hiding from the riot,” Hamilton said. “I swiftly moved our vehicle in their direction, blocked their pathway and eventually stopped them from accomplishing their task.”

But her efforts did not stop there, as she soon found herself providing aid to the future president of the country.

“Later that evening, one of the gentlemen running for president was trying to get through the town,” She said. “Our job was not to take sides in the election, but we were also there as a presence to keep the peace. We hid the gentleman in the back of the vehicle and drove him through the angry crowd. There is no doubt, that if he would have driven himself, he would not have made it. That gentleman was elected as presi-



Senior Chief Hospital Corpsman Kellie Hamilton on deployment in Sierra Leone Africa in 2007. (Photos courtesy of Senior Chief Hospital Corpsman Kellie Hamilton)

the only female assigned to the camp, you had to be assertive to survive. I remember calmly, but firmly telling the sergeant that the Marine was finished with the hike and was getting in the vehicle. As he started to argue, I remember reiterating what I had just said, but apparently a little less calmly, and a lot more firm.”

Later Hamilton, having achieved her mission to care for her Marines, would be ribbed by other at camp for stopping a six-foot-tall, 200 pound Marine in his



Senior Chief Hospital Corpsman Kellie Hamilton, then a hospital corpsman 1st class, poses with an Army staff sergeant in Pohang Korea.

dent of the country two weeks later.”

For others who have worked alongside Hamilton, they understand that being a corpsman is more than a job for her.

“Being a hospital corpsman is in se-

nior chief’s blood,” said Chief Hospital Corpsman Patrick Floyd. “She is an ever-loving and caring individual that goes far beyond what anyone can imagine when it comes to being a Sailor and a provider.”

“She was so strong during the whole time, the glue that held us all together and although I knew full-well she was human she always seemed super human to me.”

- Chief Hospital Corpsman Patrick Floyd

Her influence on others also extends beyond those she cares for.

“Kellie is a Sailor that honestly cares,” Floyd said. “She is firm and aggressive but takes every second that she can to develop the best course of action that she is going to take. I served with her on the USS Whidbey Island (LSD-41) from 2010-2012 and there was not a Single Sailor on that ship that did not know her. She was an extremely active mentor to everyone and continually wanted to learn from the few that were above her.”

Hamilton has a knack at balancing a tough demeanor when needed, providing excellent patient care, and mentoring younger Sailors. In many instances she serves as the adhesive that holds her Sailors together.

“When we pulled back home from our 10 and a half month deployment I saw her shed a couple of tears,” Floyd said. “She was so strong during the



Senior Chief Hospital Corpsman acts as the safety observer aboard the USS Whidbey Island.



Senior Chief Hospital Corpsman (right) aboard the USS Whidbey Island.

whole time, the glue that held us all together and although I knew full-well she was human she always seemed super human to me.”

While continuing her Navy career, the corpsman has been accepted into the Penn State to earn a master’s degree in Human Resources and Employment Relations – an accomplishment that only happened because of what she has learned through her military service.

“I never had the confidence when I was younger to think that a school like that would be available to me,” Hamilton said. “I joined the Navy because I didn’t believe that college was an option. Now, I firmly believe that the military has given me the confidence in myself to do just about anything that I want to do.”

For the corpsman coming after her, Hamilton offers advice that comes from nearly two decades donning a Navy uniform.

“It’s funny, the easiest and the hardest part is doing what you are told,” Hamil-

ton said. “I really believe that leadership will set you up for success if you just listen, but sometimes it’s hard when you are younger and you don’t grasp the big picture. So my advice is to do what you are told, listen to what has worked for others and don’t try to be the person who stands in the back.

Her biggest piece of advice is for young Sailors is to serve with selflessness.

“Step to the front and volunteer to do whatever is needed to get the job done,” she said. “Once you start understanding that it’s no longer just about you, that’s the winning attitude needed to make it -- regardless if it’s in the Navy or anywhere else.”

In terms of her own career successes, she attributes them to the confidence gained from those around her.

“It is having people that lead, follow and work left and right of you,” she said. “They believe in you and that builds your confidence. It’s amazing if you really think about it.”+

Navy Corpsman Finally Laid to Rest

By Mass Communications Specialist 1st Class Peggy Truillo | Defense Media Activity



Rear Adm. Peter Gumataotao presents a folded flag to Cherry Dottore, Hospital Corpsman 3rd Class Michael B. Judd's mother. Judd was finally laid to rest 46 years after dying in Vietnam. (Photos by Mass Communication Specialist 2nd Class Todd Frantom)

Only one month shy of coming home from Thua Thien-Hue Province, Vietnam, Hospital Corpsman 3rd Class Michael B. Judd, a corpsman with Company A, 3rd Reconnaissance Battalion, 3rd Marine Division, was aboard a CH-46A Sea Knight helicopter attempting to insert a team into hostile territory.

Moments later the helicopter was hit by small arms fire and crashed.

To Judd's family's relief, he eventually made it home. It only took 46 years.

Due to the location of the crash, Judd's body was not recovered until 2012, when recovery teams were able to return to Vietnam and excavate the crash site.

Officials contacted the Judd family in early 2013, which began Judd's journey to his final resting place at Arlington National Cemetery, where his family attended his burial ceremony, July 15.

"We had put our brother to rest in our minds," said Chris Judd, Michael's older brother and a Navy veteran him-



Sailors from the U.S. Navy Ceremonial Guard carry the flag and remains of Hospital Corpsman 3rd Class Michael B. Judd at Arlington National Cemetery in Arlington, Va.

self. "In February, it all came back. It's been quite an emotional rollercoaster this past few months with all the memories coming back."

As the time for the ceremony approached, Judd's concern was for his 95-year old mother.

"I wasn't sure my mother could deal with it," said Judd, holding back tears. "She's doing better than I am."

The senior Judd joined the Navy when he was 17, as a submariner.

"He was my kid brother. He came in after me," said Judd.



Joint U.S. and Vietnam recovery teams found human remains and the helicopter wreckage last year. Hospital Corpsman 3rd Class Michael B. Judd was identified through dental comparisons and other means.

Judd said that his brother served with the Marines in the Washington, D.C., area before heading to Vietnam. He had been there a year, behind enemy lines on routine patrols before he was shot down.

“He was due to come home after a year, 13 months on his birthday, to Cleveland; and he died a month short of that,” said Judd.

Judd talked about the emotional release his family has had in burying their loved one at Arlington, and about the new friends they have made in people who served with and were friends with his brother.

He became choked up once more as he spoke of the privilege in having his brother laid to rest in this place.

“We felt it was important to be here at Arlington because it’s an honor. It’s a place we can go,” said Judd, who now lives within driving distance of Arlington, in Frederick, Md.

HM3 Judd was not the only Ameri-



Hospital Corpsman 3rd Class Michael B. Judd deployed to Vietnam in 1966 and was killed less than two months before he was scheduled to return home.

can waiting for his trip home. Nearly 2,500 Americans did not return from Southeast Asia at the end of the war.

The Defense Prisoner of War/Missing Personnel Office continues to work to account for these missing Americans. +



ACUPUNCTURE

MORE THAN TRAUMA CARE

By Valerie A. Kremer | U.S. Navy Bureau of Medicine and Surgery Public Affairs
Photos by Linsey Pizzulo and Army Maj. Jeff Hall

Capt. Robert Koffman, M.D., MPH, a psychiatrist and acupuncturist at the National Intrepid Center for Excellence, Bethesda, Md., gives Army Maj. Jeff Hall, 1st Army headquarters, Rock Island Arsenal, Ill., an acupuncture treatment.

Army Maj. Jeff Hall hobbles into the military hospital in severe pain with a bone sticking out of his toe and is whisked into the emergency room by the medical staff.

Waves of voices can be heard before the surgery begins. Just moments after surgery, when the anesthesia wears off, he still feels the throbbing pain. He is suddenly met by Navy Capt. Robert Koffman, M.D., MPH, a psychiatrist and acupuncturist, who proceeds to strategically place thin needles on Hall's foot with the wound still open. The pain is suddenly lifted. It was not the first, nor last time, Hall would receive acupuncture.

Acupuncture, an ancient Chinese practice dating back at least 4,000 years, is a needle-based technique that lever-

ages linkages between various points on the body, to treat musculoskeletal and systemic complaints. Introduced to the U.S. military in 1965 in Vietnam, it is now becoming standard treatment across the private sector, Military Health System, and the services.

Mumbo-jumbo?

Before his exposure to acupuncture, Hall did not believe in it.

"To be totally honest with you, I initially thought it was a bunch of mumbo-jumbo," Hall said. "When Capt. Koffman put those needles on my foot, I honestly didn't think I could stomach it because I can hardly stand anything on my foot. But, the acupuncture was a painless way to shut off all those painful nerves firing at the same time."

In Nov. 2011, after serving two tours of duty in Iraq, Hall was coping with

post traumatic stress disorder (PTSD) and pain from several surgeries and injuries, and began treatment at the National Intrepid Center for Excellence (NICoE), Bethesda, Md.

"After starting at the NICoE, acupuncture was just part of the regiment," Hall said. "At the time, my pain levels in my back and feet were generally an eight on a scale of one to 10. I had cracked my spine in a raid in 2003 in Baghdad and ever since then, I have had chronic pain in my thoracic spine and they recognized my old injury at the NICoE. They thought that acupuncture could relieve that."

Hall was open to an alternative for pain management.

"At the NICoE, they said, 'Well, this is an alternative to narcotics' and I was all about that since going on pain meds



Army Maj. Jeff Hall, health promotion officer, 1st Army headquarters, Rock Island Arsenal, Ill., on patrol south of Baghdad, Iraq, May 2003 during Operation Iraqi Freedom.

was going backwards for me,” Hall said. “I have used opiates to mask the pain and it never helped. Acupuncture was so much better for me.”

Through his treatment, Hall also added yoga to manage his pain.

“Yoga has helped with pain. Not the twist yourself into a pretzel yoga, or high speed yoga, but I was introduced to the ‘Six movements of the spine’ through yoga,” Hall said. “Moving the vertebrae around seemed to alleviate the pain. I would say that some of the ‘weird’ modalities are the things that have worked best for me.”

More Than Pain Management

“Pain is not the only indication for acupuncture,” said Koffman, who began his medical acupuncture training prior to his 2009 deployment to Afghanistan. “In fact, my ‘Koffman Cocktail,’ which is taught in class at the Helms Medical Institute (HMI), is a combi-

nation of acupuncture points that is useful for anxiety, sleep, as well as pain. Interestingly, those traits are common for individuals experiencing PTSD.

One treatment gives you a triple threat against all of those symptoms.”

Koffman, who practiced acupuncture as part of a Mobile Care Team at various — and sometimes remote — locations in Afghanistan, has found acupuncture

to be a useful treatment for PTSD and other psycho-emotional treatments, which he calls, “Seven dragons for seven demons.”

“I like treating pain [with acupuncture] because I can get immediate buy-in from patients,” Koffman said. “If I can make patients more comfortable and relieve their pain, then I can get better buy-in with regards to using other

“The acupuncture was a painless way to shut off all those painful nerves firing at the same time.”

- Maj. Jeff Hall



Capt. Robert Koffman, chief of Clinical Operations at the National Intrepid Center of Excellence, Bethesda, Md. administers an acupuncture treatment to a patient suffering from migraine headaches and chronic pain. The technique, called the 'Koffman Cocktail' is particularly effective at relieving headaches and pain.

psychiatric therapies. Also, if they have less pain, they can be more compliant with regular psychotherapy.”

Acupuncture use in Navy Medicine

According to Koffman, acupuncture across the Navy Medicine enterprise, is used in a variety of settings varying from neurology to gynecology.

“Medical acupuncture is very useful for the primary care providers because of the many different organ and organ systems that acupuncture can influence and affect,” Koffman said. “It is also helpful for specialists and there is typically a condition that acupuncture will be their go-to remedy for. Acupuncture is used for a variety of conditions — whether its interstitial cystitis for gynecologists, or migraines for neurologists, or irritable bowel for gastroenterologists — but the functional disorders which are so vexing

for providers, are the types of disorders that tend to respond well to acupuncture.”

In March 2013, Vice Adm. Matthew L. Nathan, U.S. Navy Surgeon General, and chief, U.S. Navy Bureau of Medicine and Surgery, signed the first acupuncture policy in military history to provide standard guidelines for acupuncture training, privileging, and use across Navy Medicine. Championing the instruction, the Navy Comprehensive Pain Management Program (NCPMP), was established to ensure access to standardized pain management, including Complementary and Alternative Medicine (CAM), for all beneficiaries.

The instruction grants supplemental privileges to doctors, dentists, physical therapists, and chiropractors for medical

acupuncture (including auricular (ear) and chiropractic). The policy also enables licensed acupuncturists to practice throughout Navy Medicine as ‘privileged provider extenders’ and allows non-privileged providers, such as nurses and corpsmen, to use auricular acupuncture as ‘privileged provider extenders’.

“Acupuncture is probably the most predictable method of modulating or eliminating pain,” Koffman said. “At the NICoE, we’re able to substantially lower the narcotic burden that patients have. That’s a huge relief from the pain burden in service members, wounded warriors and returning service members today, and another reason why Navy Medicine needs to be training more providers. The new instruction helps to make that possible.”

According to the NCPMP, from fiscal



Maj. Jeff Hall, on patrol north of Tahji, Iraq 2005.

2010 to fiscal 2012, Navy Medicine acupuncture use almost doubled from 7,419 to 13,916 encounters. As acupuncture becomes more common, more personnel are likely to receive training.

Another reason why Navy Medicine providers need to be trained in acupuncture is because service members want choices, according to Koffman.

“They may not want acupuncture, but they want to be told that acupuncture is an option,” Koffman said. “They want to be told that Alpha-Stim, qigong, and yoga are options. They don’t want to be told to queue in front of the pharmacy to pick up their next prescription.”

Types of Acupuncture

There is a distinction between traditional five-element Chinese acupuncture, medical acupuncture, and battlefield acupuncture (BFA), also known as auricular acupuncture. The training involved in five element acupuncture is more extensive, with medical acupuncture being taught in 300 hours, and BFA, with only five specific points, which can be taught within a day.

“I strongly support corpsmen to be taught battlefield, or first-aid, acupuncture,” Koffman said. “It’s an easy procedure to learn and many people will respond well to it. The auricular acupuncture works because the ear is

a micro system — every point on the body is represented somewhere on the ear.”

Acupuncture Across the Services

According to Koffman, approximately 250 military physicians have undergone comprehensive training programs in medical acupuncture since 2009 when the U.S. Air Force, Navy, and Army began sponsoring active duty military physicians. The goal of the training is to provide the techniques of this emerging discipline as primary or complementary treatments for the three major problems areas from the last decade of warfare: acute and chronic pain, acute and chronic stress disorders, and concussion.

“There is definitely jointness across the services with the use of acupuncture,” Koffman said. “The Air Force actually brought BFA to the three services

and has taught auricular pain control. Similarly, all the three services also attend HMI and learn a similar model of acupuncture. There is great work being done there.”

Acupuncture as an Option

Acupuncture may not be for the squeamish or those fearful of needles, but, according to Hall, he highly encourages it.

“Even coming from a grunt mentality, I know it sounds like ‘hocus-pocus,’ but you should absolutely try it to see if it works for you because it’s definitely an alternative to over-medication or the risks of using medication to mask pain,” Hall said. “The first time I had acupuncture — me and my wife took it together — we felt like we were floating, completely pain free.”

Hall, a graduate of Emporia State University, is currently a health promotion officer, 1st Army headquarters, Rock Island Arsenal, Ill., where he continues to advocate for soldiers health issues and continues to share artwork that has been a big part in his treatment for PTSD. During his 19 year career, he has received two Bronze Stars among others. Hall and his wife work closely with the Real Warriors Campaign helping to breakdown the walls of stigma associated with getting treatment for PTSD and traumatic brain injury.

“I honestly wouldn’t come back and get retreated by Capt. Koffman when I come back to DC if acupuncture did not work,” Hall said. “I think it’s very important for practitioners or care management teams to understand the importance of acupuncture as an alternative to pain management. I would like our medical treatment centers to consider making acupuncture part of their programs.” +

“They may not want acupuncture but they want to be told that acupuncture is an option.”

- Capt. Robert Koffman

RECON DOC



Story and photo by Cpl. Corey Dabney | 1st Marine Division

Reconnaissance Marine is a title earned through going through some of the most physically demanding training in the Marine Corps.

Recon Marines must be able to provide reconnaissance and surveillance of enemy objectives and also be able to perform as the basic infantryman.

A part of the recon family often overlooked is the Special Amphibious Reconnaissance Corpsmen (SARC) who bear the weight and responsibility of keeping the Marines safe and keeping up. A SARC is a Navy corpsman who's gone through a pipeline of training to earn the title of SARC. Their schooling consists of Basic Reconnaissance Course, Amphibious Reconnaissance Course, Marine Combatant Diver's Course, Basic Airborne Course and the Special Operations Combat Medic Course.

Navy Hospital Corpsman 2nd Class Jason Bennett, a SARC in training serving with Alpha Company, 1st Reconnaissance Battalion, pushes himself while training to join the ranks of these elite Sailors.

Bennett, 29, from Carrollton, Texas, has completed two of the physically and mentally demanding courses needed to become a SARC, and said he can't wait to attend the next.

"The training is definitely a butt-kicker, but it is worth it," Bennet said. "I get to train with some really great Marines that never quit, and they accept me into their teams because I've done the exact same training as them."

The training is unique because of the intense level of training and the fact they go through every type of training the Marines go through, said Navy Chief Hospital Corpsman Daniel Lang, the leading chief petty officer for Headquarters and Support Company and Force Reconnaissance Company, 1st Reconnaissance Battalion. If the Marines are doing shooting packages or jump packages, so are the SARCs, he added.

SARCs bring new capabilities to the units they attach to, not just because of the 14 months of medical training they complete on how to save and sustain life during Special Operations Combat Medic Course, but because of the arduous combat training they go through.

"These Sailors have to be able to pull their



Hospital Corpsman 2nd Class Jason Bennett, a Special Amphibious Reconnaissance Corpsman in training serving with Alpha Company, 1st Reconnaissance Battalion, shows he has what it takes to become a SARC in the U.S. Navy. Bennett, 29, from Carrollton, Texas, has completed two of the five courses needed to become a SARC and said he can't wait to join the ranks of this elite group of Sailors.

own slack when they are working alongside the Marines. So, yes, the training is tough. But when they complete it, they know they can hold any billet in the team that a recon Marine can," said Lang. "Will a SARC walk point in a team? Probably not. But can he? Absolutely, and that's what they bring to units, the ability to do anything the team needs them to."

Being a SARC isn't something that any Sailor can do, and Bennett said he learned that the hard way. He has seen people quit while training because how hard some of the training has been on their bodies.

"The training usually always weeds them out, because most people aren't mentally prepared for this level of training," Lang said. "It takes an iron will to do what these men do.

Being strong helps, but I'd take smart with a never give up attitude over strength any day."

Bennett has a long way to go with the three courses he has to complete to become a SARC, but he said he knows that he will make it and become a SARC.

"Quitting isn't even an option after I have come this far," Bennett said. "I've worked too hard to just drop my pack."

He can't wait for the day when he can finally say he has earned the title of SARC, Bennett added.

"The feelings you have when you become a SARC is different for everyone, but that feeling of accomplishment and belonging I felt when I did has never faded," Lang said. "That's something that's going to be with me forever."+



Navy corpsmen with 1st Medical Battalion, 1st Marine Logistics Group, wrap a simulated casualty victim during the first public mass casualty drill aboard Camp Pendleton, Calif. Marines and Sailors demonstrated their emergency response skills to several friends and families who attended the event.

MASS CASUALTY DRILL

Story and photos by Cpl. Laura Gauna | 1st Marine Logistics Group

Marines and Sailors with 1st Medical Battalion, 1st Marine Logistics Group, displayed their medical expeditionary capabilities to dozens of spectators during the first public mass casualty drill aboard Camp Pendleton, Calif., June 5, 2013.

The drill simulated an improvised explosive device attack on a convoy. The corpsmen had to respond quickly to sort through the casualties, provide life-saving techniques to stabilize the critically wounded and call for a medical evacuation in a high-stress environment.

“We are trying to show what we can do for the Marines and the community and how we can support with our medical abilities,” said Navy Lt. Keith

Nemeroff, a company commander with Charlie Surgical Company, 1st Medical Bn., 1st MLG, and a native of Philadelphia. “It’s great to show everyone what we can do and all the hard work that we put into training every day.”

The personnel set up a field hospital capable of treating up to 50 patients, 20 percent of whom could be critical patients, within a 24-hour period.

Seven Marines, who role-played as casualties, arrived to the medical team. Each entered the tents screaming, pretending to suffer different injuries and wounds for the corpsmen to treat. Injuries included sucking chest wounds, shrapnel to the eyes, missing limbs and external fractures.

The corpsmen assessed each patient and either treated him on the spot if their condition required immediate attention or moved them through the emergency tents to receive further treatment.

Marines portraying casualties wore detailed moulages and special effects makeup, bringing injuries such as face lacerations, compound fractures, severed body parts and puncture wounds to life. These injuries tested the team’s proficiency in applying life-saving procedures and stabilizing the victims prior to evacuation.

As the casualty drill concluded, leaders of the emergency teams on scene gathered to review the corpsmen’s per-



Navy corpsmen and surgeons with 1st Medical Battalion, 1st Marine Logistics Group, tend to a simulated casualty victim during the first public mass casualty drill aboard Camp Pendleton, Calif.

formance and note areas of improvement. Brig. Gen. John J. Broadmeadow, commanding general, 1st MLG, shared his thoughts as well.

“The crew that you saw here are very experienced from doing this for real in Afghanistan,” said Broadmeadow. “They saved real lives, not mannequins, no moulage. I appreciate all the hard work that you all put into the exercise today.”

Many personnel participating just returned from Helmand Province, Afghanistan, where their patient survival rate was 98 percent.

“The scenario we ran today is what we saw in our deployment,” said Navy Hospital Corpsman 3rd Class Jonathan Ramos, a field corpsman with Charlie Surgical Co., 1st Medical Bn., 1st MLG, and a native of Laredo, Texas. “With this exercise we are able to teach our new members how things work when we are forward deployed. We can share our stories and our experiences and set the foundation for their success when they go forward and deploy.”

Several families came to witness the drill and see what their loved ones experienced while deployed.

“It’s great for the families to see what



Navy corpsmen with 1st Medical Battalion, 1st Marine Logistics Group, transport a simulated casualty victim to the shock trauma platoon tent during the first public mass casualty drill aboard Camp Pendleton, Calif.

we do every day and show them this is what their wife or husband does for a living,” said Nemeroff. “I have never worked with such a great group of professionals as I have here. This is what makes this job so rewarding.”

In the end, the exercise brought to life the importance of having these capabilities.

“Expeditionary medicine itself is an important asset to any fighting force out there,” said Ramos. “Having a resource like this that can be set up anywhere and save the lives of our Marines, Airmen and Sailors is a huge benefit. Having this asset in the battlefield or beachhead or wherever brings up our survival readiness.” +

ONCE A CHIEF ALWAYS A CHIEF

By Petty Officer 1st Class James Stenberg | Naval Hospital Pensacola



Senior Chief Hospital Corpsmen Patrick Undergraff and Bobby Pilgrim, both with Naval Hospital Pensacola's Chief Petty Officers Association, support Charles Wheeler as he tells of his experiences in the Navy during World War II May 29 in Foley, Ala. NHP's CPOA volunteered to help Wheeler with some yard work the 94-year-old retired chief is no longer able to do.

A common saying among the Navy's eternal brotherhood of chief petty officers is "Once a Chief, Always a Chief." That expression was clearly evident when 12 members of Naval Hospital Pensacola's Chief Petty Officers Association arrived May

29 at the home of 94-year-old Charles "Chuck" Wheeler, retired chief, to help with everyday tasks he is no longer able to do.

A 28 year veteran, Wheeler served aboard USS Enterprise CV-6 from May 1941 to February 1944 as an aviation ordnanceman. During that time, the Enterprise participated in numerous engagements against the Japanese Navy in-

cluding the Battle of Midway, the Battle of the Eastern Solomons, the Battle of the Santa Cruz Islands and various other air-sea engagements during the Guadalcanal Campaign.

"I don't have the words to express my gratitude in relations to what you all are doing for me," Wheeler told the group. "Any little thing helps me tremendously. I used to be able to mow the lawn, pick



Chief Hospital Corpsman Michael Arceneaux, with Naval Hospital Pensacola's Chief Petty Officers Association, works on a fence during a volunteer clean-up for a retired World War II veteran. Chiefs from NHP's CPOA gathered at the home of Charles "Chuck" Wheeler May 29 in Foley, Ala., to do various yard work that he is no longer able to do.

up blown down limbs and leaves and maintain the place.”

When the NHP CPOA was approached about the opportunity to assist, they embraced it whole heartedly.

“As soon as this was presented to the chiefs, no one in the association hesitated for a second,” said Chief Hospital Corpsman Chi Patrick. “[Helping] is what we do. When a fellow chief needs help, we just do it.”

Although the work was not what some people would call important, it was very important to those who volunteered to do the work and who it was done for.

As the chiefs arrived, they split up into groups to accomplish several tasks such as mowing the lawn, removing a

section of an old fence and digging up fence posts. The group of senior enlisted leaders was eager to help in any way they could.

“We’re just doing some yard work and simple home beautification for a retired chief,” said Chief Hospital Corpsman Chris McKenzie. “The fact that he, as a chief, paved the way for who I am today, blows my mind. To think what [veterans] went through so that we could have the luxury that we have today makes me feel really honored to be here.”

About halfway through the morning, Wheeler came outside to talk with this new generation of chiefs.

“I’m excited, I really am,” said McKenzie. “When I talked to him, he came

alive talking about his battle experiences and some of the things he went through. It is one thing to read a history book, but when you can talk to living history, it’s just a phenomenal thing for me. It’s been a truly great experience.”

After several sea stories reminiscing of old times and a few shared laughs, Wheeler returned inside and the chiefs resumed their work.

When asked what he thought of Wheeler’s service to the country, Chief Logistics Specialist Brian Garfield said, “It’s priceless, that’s one of the types of services that can never be repaid.” “We can only stay committed to make sure we meet the mission all the time like [veterans] did back in that time. We will always be in debt for that service.” +

SAVING A LIFE

Story and photos by Sgt. Bryan Peterson | Regional Command Southwest



Hospital Corpsman 3rd Class Stanley Maculewicz, Afghan National Army (ANA) 215th Corps Mobile Strike Force Security Force Assistance Advisor Team (SFAAT), and ANA Staff Sgt. Abdul Malik are reunited at Camp Shorabak, Helmand Province, Afghanistan, June 15. During recent operations in Sangin, where Afghan National Security Forces cleared Taliban from one of Afghanistan's more volatile districts, Malik and a fellow ANA medic were recovering a fallen soldier, when Malik was hit by enemy fire. The bullet struck him below his right kidney and exited his right side. Maculewicz rushed to his aid to treat his injury and ensure he was safely evacuated from the battlefield.

When U.S. Navy Petty Officer Stanley Maculewicz visits Camp Shorabak to advise the Afghan National Army (ANA) 215th Corps Mobile Strike Force Kandak medics, he is usually welcomed with hugs and handshakes from his counterparts.

Shortly after arriving at the Afghan camp, June 11, his boss, Maj. Brian J. O'Shea, the MSF Security Force Assistance Advisor Team officer in charge, called his name and told him an ANA soldier was looking for him. He stopped what he was doing. He took a few steps and stopped in his tracks when he saw the soldier.

"I couldn't believe it," said Maculewicz, as he stared at ANA Staff Sgt. Abdul Malik.

The two didn't say a word. No handshakes – they just hugged for a while.

Maculewicz was thrilled, to say the least. Just two weeks before, he performed life-saving steps on Malik and called in an air medical evacuation

during Operation Aoad Se Hasht (38 Eagle) in Sangin.

The operation was an Afghan National Security Forces response to a Taliban attack on Afghan Local Police and Afghan Uniformed Police patrol bases.

During the first week of the operation, which saw some of the heaviest fighting, Malik and another MSF medic were recovering a fallen soldier. Malik loaded the soldier into an ambulance and was about to open the driver's door when a bullet punched through his back, below his right kidney and exited from the right side of his abdomen.

Around the time Malik was responding to the casualty call, Maculewicz was at the casualty collection point at Patrol Base Tobaq, from which the MSF ANA medics were operating. Unaware of Malik's situation, he heard the call about a soldier killed in action. Minutes later, he heard another call come in about a soldier who was wounded.

"I initially thought there was some

confusion in the communication, because I just had heard there was a KIA," said Maculewicz, "so, I thought it was just a wounded soldier. Either way, I was getting ready for what was coming my way. I was making sure my ANA medic was prepared as well, should we take a casualty."

Then the ambulance pulled up.

Quickly getting in the mindset

Maculewicz said his biggest fear was that if the time ever came to save someone's life, he would freeze.

Compared to his previous duty station at Walter Reed National Military Medical Center in Bethesda, Md., where he worked in the Traumatic Brain Injury Ward, the life-saving acts he performed on Malik "were night and day."

At Walter Reed, the Washington Township, N.J., native worked in shifts and had set schedules. He had a routine – and time to think things through.

Now, Maculewicz is on his first combat deployment and it is his first time

serving with a Marine Corps unit. He is also the only corpsman on the MSF SFAAT. His workload is a complete 180 from his time in Bethesda. There is no set schedule or routine. He learned that from Field Medical Training Battalion at Camp Johnson, N.C.

“When I was at FMTB, where you learn how to be a combat corpsman before joining a [Marine Corps] unit, they put you in situations like I was with Malik,” he said. “But, when you’re in a training environment, the person still lives. It’s just training.

“But the instructors always told us, ‘once you’re in that moment, it will automatically click in your head,’” he added.

The ambulance arrived, Maculewicz’s training kicked in

“I opened the door and blood came pouring out” as the ANA medics pulled the KIA out of the vehicle, said Maculewicz. “I helped pull the wounded soldier out and didn’t even realize who it was. I began working on him immediately.”

He said “a million things” ran through his mind. He was looking for wounds to Malik’s chest, arms, abdomen and leg.

“Each part of the body requires different treatments,” he said. “Even if it’s a gunshot wound in the arm or the leg, each will require different measures.”

Once he located the injury, he began stabilizing Malik. He treated Malik’s back and rolled him over to treat the exit wound. He looked at the interpreter and told him to reassure his patient everything was going to be ok. Then he glanced at his face—and realized who it was.

Without a pause, he applied a chest seal on the wound.

At that moment, Maculewicz said irony had struck.

“The day before the operation began, I was training the medics about keeping a patient breathing should they have an open wound between their chest and hips,” said Maculewicz. “Malik was my go-to medic so I applied a chest seal on him [to demonstrate for the class]. Now, I was doing it to save his life.”

He couldn’t tell if there was any internal damage, but he didn’t want that to go unnoticed. He knew Malik would have to be medically evacuated by helicopter.

While treating Malik, he reassured him everything would be fine, while



Hospital Corpsman 3rd Class Stanley Maculewicz, Afghan National Army 215th Corps Mobile Strike Force Security Force Assistance Advisor Team (SFAAT), and ANA Staff Sgt. Abdul Malik shake each other’s hands at Camp Shorabak, Helmand Province, Afghanistan, June 15.

relaying information to a Marine who was calling in the request for air medical evacuation.

“It was a lot of pressure that day because in addition to all I had to do to get Malik out of there, there were also more than 20 ANA soldiers watching me,” he said.

The helicopter arrived shortly after Malik was stabilized. He was loaded up on the ambulance, driven to the landing zone and Maculewicz said what he thought were the final goodbyes.

“I thought I wasn’t going to see him after that,” said Maculewicz. “I mean, I was confident he was going to be fine, but I just didn’t think he would be back at the unit.”

Wanting to give thanks

Malik didn’t remember much from the time he was shot to the time he arrived at the patrol base, but he did remember watching Maculewicz working on him – and knowing would be fine because “Doc is a great teacher.”

He spent two days at the Camp Bastion Role 3 hospital and one week at Camp Shorabak’s clinic.

While recovering, he awaits orders for convalescent leave to go back to Kabul to see his family and newborn son – but wanted to see Maculewicz first.

The two spent more than an hour catching up, talking about the injury and the fighting in Sangin.

“He saved my life,” said Malik. “I can’t repay him for what he did for me,

but I am going to get back to my job and keep fighting the Taliban. I will be back and be there for my soldiers’ medical needs, just like Doc was there for me.”

Maculewicz was surprised to see Malik walking, talking and laughing “as if nothing happened.”

Malik plans to spend his leave telling his friends and family about his experience, but “most importantly, I am going to tell everyone about my friend, Doc, who is the reason why I’m here today. It is my hope the people I tell spread the word about the Americans and their good intentions in Afghanistan.

“We call our fallen soldiers, heroes,” Malik went on to say, “but Doc is my hero too.”

Every time Maculewicz conducted training, he said Malik always volunteered first. “He took the training to heart and he was an example to his medics,” Maculewicz said. “We have become close during this deployment.”

Maculewicz considers Malik a friend and said when he saw him lying wounded at PB Tobaq, it hit him “harder because it would have been like treating a Marine I’ve known on this deployment.”

He said he’s no hero; rather, he merely did what he signed up to do.

“My mom tells me she’s going to slap me upside the head because she keeps telling me I’m too modest,” he laughed. “I guess I know what’s coming when I come home.” +

NAVY CORPSMEN | 7



Hospital Corpsman 1st Class Darnell Mason, Headquarters Company, Regimental Combat Team 7 competes in a grappling tournament on Camp Leatherneck, Afghanistan. *(Photo by Marine Corps Cpl. Kowshon Ye)*



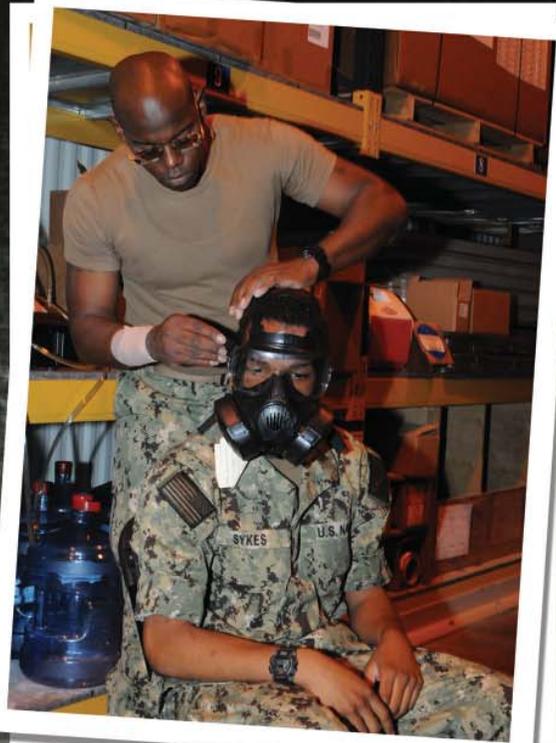
Hospital Corpsman 2nd Class Weiran Wang undergoes equipment familiarization training with a new GE Optima 64-slice CT scanner at U.S. Naval Hospital Yokosuka, Japan. The hospital is the largest U.S. military treatment facility on mainland Japan and provides medical and operational support to active duty, family members and other eligible beneficiaries in Japan, Korea and Diego Garcia. *(Photo by Mass Communication Specialist 3rd Class Amanda S. Kitchner)*



AROUND THE FLEET



Hospital Corpsman 3rd Class Ricardo Arrequin, from North Richland Hills, Texas, and assigned to Georgian Liaison Team-9 surveys his surroundings while providing security during operation Northern Lion II in Helmand province, Afghanistan. Northern Lion II was a Georgian led operation conducted to deter insurgents, establish a presence, and gather human intelligence in the area. (Photo by Marine Corps Cpl. Alejandro Pena)



Hospital Corpsman 3rd Class Brandon Gorman checks the fit on Logistics Specialist Seaman Sidney Sykes' gas mask during gas mask issue. Gas mask issuance is a common practice for deployed naval personnel. (Photo by Mass Communication Specialist 1st Class David R. Krigbaum)



Army Spc. Cathy Mason and Navy Hospital Corpsman 2nd Class Sarah Godette move a simulated wounded service member onto Forward Operating Base Young's flight line for medical evacuation on a C-130 airplane at Fort McCoy, Wis., during Warrior Exercise 86. Mason, a native of Waynesburg Penn, is a medic with the 901st Minimal Care Detachment, Fairmount, W.V., and Godette, a native of Salt Lake City, serves with Detachment K, Operational Support Hospital Unit, Bremerton, Wash. Soldiers, Sailors and Airmen came together to work towards the common goal of caring for and evacuating wounded from the battlefield. (Photo by Army Sgt. Francis Horton)

NAVY CORPSMEN | 7



Hospital Corpsman Darriel Steedman, a Special-Purpose Marine Air-Ground Task Force Crisis Response corpsman and Jacksonville, Fla. native, left, and Petty Officer 1st Class Jon Trumble, an independent duty corpsman with SP-MAGTF Crisis Response and Centuria, Wis. Native, attempt to paddle their cardboard boat to victory during the Independence Day "Build Your Own Boat" race aboard Moron Air Base. (Photo by Marine Corps Staff Sgt. Lukas Atwell)



Chief Hospital Corpsman Richard Bestwick, left, with the Search and Rescue Model Manager Department, Helicopter Sea Combat Squadron (HSC) 3, and Hospital Corpsman 2nd Class Brent McIntyre, right, assigned to Naval Air Station Whidbey Island Search and Rescue (SAR), attend to a simulated victim during a training rescue as part of an annual SAR evaluation in Oak Harbor, Wash. (Photo by Mass Communication Specialist 1st Class Joan E. Jennings)

AROUND THE FLEET



Hospital Corpsman Brandon Dewitt restrains Religious Program Specialist 1st Class Christina Clevenger after being sprayed with oleoresin capsicum (OC) spray aboard the amphibious dock landing ship USS Carter Hall (LSD 50). Carter Hall is a part of the Kearsarge Amphibious Ready Group deployed in support of maritime security operations and theater security cooperation efforts in the U.S. 5th Fleet area of responsibility. *(Photo by Mass Communication Specialist 3rd Class Sabrina Fine)*



Hospital Corpsman 3rd Class Ricardo Arrequin adjusts U.S. Marine Corps Cpl. Arnold H. Cabral's gear as he relays a radio message during Operation Northern Lion II in Helmand province, Afghanistan. Arrequin and Cabral, from North Richland Hills, Texas and Modesto, Calif., respectively, are both assigned to Georgian Liaison Team-9. *(Photo by Marine Corps Cpl. Alejandro Pena)*



Nurse Practitioner Lt. Cmdr. Carrie Glenn examines a patient at Martin Middle School in Martin, Tenn. Glenn, assigned to Navy Operational Support Center Ventura County, Calif., along with more than 40 other Navy Medicine professionals, are participating in the Hope of Martin community outreach project, an Air National Guard-led initiative providing medical care during the Hope of Martin Innovative Readiness Training mission which is designed to train U.S. military medical personnel and provide assistance to underserved communities.

HOPE OF MARTIN

Individual Readiness Training supports Tennessee communities

Story and photos by Mass Communications Specialist 1st Class Bruce Cummins | NMETC Public Affairs

“If there's ever a picture you could hold up and say, 'This is how an IRT is supposed to run and come together,' this would be the picture.”

That's how Capt. Janie Brier, a Navy nurse, described the nearly two-week joint-service Hope of Martin Innovative Readiness Training (IRT) exercise.

Hope of Martin was an Office of the Secretary of Defense (OSD)-sponsored initiative held July 8-19 at Martin Middle School in Martin, Tenn. Nearly 40 Reserve Sailors integrated with their Air

Force and Air National Guard counterparts to set up and staff a clinic capable of providing medical and dental care in an area of the country with staggering unemployment and a significant population with no health insurance.

Military leaders on the ground like Brier, the Hope of Martin IRT medical director, indicated the Hope of Martin Innovative Readiness Training (IRT) mission surpassed expectations. Those expectations were to enhance reserve service members' readiness, create a

joint working environment, and provide much-needed care to the medically underserved communities in and around Martin.

Navy Medicine Education and Training (NMETC) Reserve Component Reserve Sailors staffed some of the Hope of Martin positions. NMETC Reserve Sailors and their sister service counterparts provided medical, dental, pharmaceutical and ophthalmology services to several thousand Martin and surrounding area residents.



Capt. Mike Radoiu, a Medical Service Corps optometrist from Expeditionary Medical Facility Bethesda, administers eye drops to a patient at Martin Middle School in Martin, Tenn.

By the time the joint-service team of more than 130 closed the doors, they had touched the lives of more than 3,200 West Tennessee residents, performing more than 9,000 procedures, manufacturing more than 1,100 pairs of eye glasses, and filling more than 8,500 prescriptions.

Brier said the challenge of integrating personnel from different military service cultures proved negligible from the mission's onset, something she attributed to the commonalities of a shared mindset.

"We all have that healthcare background, we have that culture of care, we speak a common language, and we have common standards of practice," she said. "People came together and embraced the mission and made it their own."

Brier said mission success was also enhanced by the community embracing the military team.

"We could not have asked for better support," she said. "We became a part of the community. We lived and worked here. We would see these people when we went out to buy supplies, when we

went out to exercise. And because we felt a part of the community, we felt we were providing care to our friends, our neighbors. This made it so much more important to us."

"Navy Medicine professionals are always willing to provide the best care possible," said Capt. Gail Hathaway, MSC, NMETC commander. "Joint efforts like this with Air Force and Air National Guard personnel are helping solidify the relationship between our men and women in uniform and those they have chosen to protect. Going into an area with limited medical facilities and providing care helps those on our own soil and helps better prepare our reserve medical forces fulfill their mission of saving lives on the battlefield. I'm very happy with our NMETC reserve team."

Civil-Military Programs such as the Hope of Martin IRT are in keeping with a long military tradition of leveraging training to benefit both military units and their home communities and are strongly supported by Department of Defense, Congress, the states and the lo-

cal communities. Air Force Col. Damon S. Feltman, deputy director of training program management for the Office of the Assistant Secretary of Defense for Reserve Affairs, said the military services have always brought to bear their extensive knowledge to help meet some of the country's civil needs. In recent years, DOD has realized the simultaneous benefits these civil-military programs can offer to military readiness.

"After more than a decade of war, the guard and the reserves are at their highest level of readiness they have been at in generations," he said. "IRT projects keep them trained and ready."

The trained and ready service members involved in the Hope of Martin IRT saw days with sometimes hundreds of patients waiting in line for the doors to open at 8 a.m. Some of those traveled hundreds of miles and waited all night to receive services.

After visiting a triage area, filling out requisite paperwork and being divided into groups designated for the type of care they were to receive, patients began



Capt. Mary Ann Gonzalez injects an anesthetic into the mouth of a patient during the Hope of Martin Innovative Readiness Training (IRT) at Martin Middle School in Martin, Tenn. Gonzalez, along with more than 130 other Air National Guard, Air Force and Navy Medicine professionals, are participating in the Hope of Martin community outreach project, an Air National Guard-led initiative providing medical care during the Hope of Martin Innovative Readiness Training mission which is designed to train U.S. military medical personnel and provide assistance to underserved communities.

seeing medical professionals. Services the Hope of Martin IRT provided included medical care such as physicals, mental health services, dental procedures and eye exams. Patients also had

access to an occupational therapist, a dietician and pharmaceutical services. Vision care included screenings and eye glasses manufactured on site in the Mobile Optical Lab. Information about

additional medical resources and health care facilities in the community were also provided on site.

Brier said Hope of Martin IRT was meant to provide members of a joint-service medical team a real-world scenario similar to what they might experience during deployments while demonstrating the positive life saving and life improving impact they can have on a community.

"From the military's aspect, this provides us the real-world training we need to perform humanitarian missions, disaster relief and life-saving combat support missions globally," Brier said. "From the community's perspective, we're able to deliver free care, care that is in great demand. An added benefit is the immediate pride and satisfaction we get knowing we touched someone's life."

Hope of Martin IRT medical pro-

“This sort of experience has served to prepare them for a future deployment that could very well see them working with members of other services.”

- Senior Chief Hospital Corpsman Jeff Tabor, Hope of Martin senior enlisted adviser



Occupational Therapist Lt. Cmdr. Patrick Murray, Hope of Martin Mission officer-in-charge, sees a patient during the Hope of Martin Innovative Readiness Training (IRT) at Martin Middle School in Martin, Tenn.

professionals worked significant hours during the exercise, an effort designed to maximize the number of patients medical providers were able to see on a daily basis. For some of the more sought after medical services - primarily dental and optometric - that meant particularly long hours, with providers often foregoing meals to ensure the number of patients they could assist was maximized.

Hope of Martin IRT Senior Enlisted Adviser Senior Chief Hospital Corpsman Jeff Tabor said this mindset, coupled with the unique opportunity to train with fellow medical professionals in sister services, provided a unique opportunity.

"None of us knew each other before the mission, but we seamlessly bonded," he said. "With the opportunity to work

with our sister services came the opportunity to train with them as well. Corpsmen were working with Air Guard optometrists to maximize their capabilities and learn new skill sets while Air Guard personnel were working as a team with Navy dentists to learn new skills they can bring to their unit. There were service members wearing different uniforms who became one team with one common mission."

Tabor added that the reality of deploying in a joint environment exists now more than ever before, and the opportunity for these medical professionals to experience that first-hand is something that will prove beneficial in the future.

"These corpsmen, Air Guardsmen and Airmen are the future of military

medicine," he said. "This sort of experience has served to prepare them for a future deployment that could very well see them working with members of other services. Having had this experience, having had the opportunity to work together, helps ensure a successful mission in the future."

NMETC is the sole point of accountability for formal Navy Medicine education and training services, and is part of the Navy Medicine team, a global health care network of Navy medical professionals around the world who provide high-quality health care to more than one million eligible beneficiaries. Navy Medicine personnel deploy with Sailors and Marines worldwide, providing critical mission support aboard ships, in the air, under the sea and on the battlefield. +

A DAY IN THE LIFE

PRT Farah's Medical Team in Afghanistan



Story by Navy Lt. j.g. Laura Cook and Army Spc. Nkelo Kurtz with foreword by Navy Lt. j.g. Matthew Stroup | Provincial Reconstruction Team Farah

U.S. Army Spc. Nkelo Kurtz, medic for Provincial Reconstruction Team (PRT) Farah, takes a break after treating and evacuating numerous simulated casualties during medical evacuation training on Forward Operating Base Farah. PRT Farah coordinated with C Company, "Northstar Dustoff," 2-211th Aviation Regiment (Air Ambulance) pilots and medics in order to provide invaluable hands-on medical evacuation training. (Photo by Chief Hospital Corpsman Josh Ives)



On a remote Forward Operating Base in Afghanistan's westernmost province, U.S. Navy Lt. j.g. Laura Cook and U.S. Army Spc. Nkelo Kurtz have an uncommon partnership.

She is a Navy physician assistant on an individual augmentee assignment and he is an Army combat medic

deployed with Bravo Battery 2-12 Field Artillery Regiment. Her home base is Naval Submarine Base Kings Bay, Ga., on the East Coast and he is based out of Joint Base Lewis-McChord in Tacoma, Wash., on the West Coast. Currently, they are both assigned to the Provincial Reconstruction Team Farah Medical Team.

As the only medical officer assigned to PRT Farah, Cook oversees daily operations of the base aid station and a staff of about ten medical personnel. She and her team provide care for all military, civilians and local national personnel working on the base.

Cook also works with provincial public health officials in a train, advise and assist role as part of the PRT's primary mission. Kurtz assists her with aid station operations, including sick call services, supply and inventory and teaching combat life saver courses. He also supports PRT missions outside the wire as a duty medic.

When trauma patients are medically evacuated to the base, Cook and Kurtz's team receives and triages them, and sends the most critical patients directly to the forward surgical team who are co-located on the base with the PRT's medical team. Less critical patients are stabilized, evaluated and treated on-site.

In the following paragraphs Cook and Kurtz provide a glimpse into a typical day in their lives, each providing insight from their own experiences with Provincial Reconstruction Team Farah.

Mission Prep, Sick Call and Training

7:45 a.m.

Kurtz: We prepare for sick call by inspecting our equipment to ensure it is in good working order, and our patient rooms to ensure they are stocked. It doesn't seem like much, but it's important to save time when patients come. We don't want to have to search for an item in a supply container elsewhere on base, or spend time restocking when we



U.S. Army Spc. Nkelo Kurtz, left, a medic assigned to Provincial Reconstruction Team Farah, assists U.S. Navy Lt. j.g. Laura Cook, center, a physician assistant with the PRT, to treat a member of the Afghan National Army who sustained combat related injuries at the FOB Farah battle aid station. (Photo by Lt. j.g. Matthew Stroup)

could have had it pre-staged beforehand. The daily medic on duty also does maintenance checks on the field litter ambulance (a Humvee outfitted for patient transport) and the gator multi-use vehicle. We need these vehicles ready at a moment's notice to pick up patients or drop off patients.

Cook: The clinic staff arrives and prepares for the day's routine while the mission and quick-reaction force (QRF) medics are already busy with their respective duties. The mission medic will go out with other PRT personnel on missions if one is scheduled for the day. The QRF medic waits on base in a mission ready status in the event a supplementary force is needed by the team on mission.

8:00 a.m.

Kurtz: Mission days are completely different than days working as the sick call medic on base. On mission days, pre-combat inspections and pre-combat gear checks are performed by the non-commissioned officers on the security

force team to make sure that we all have the gear that we will need. Outside the wire, anything can happen – we have to be ready no matter what.

Cook: We hold sick call three times daily, except one day per week when we have sick call only once to recharge the medical staff's batteries and handle any tasks not finished throughout the rest of the week. The variety of illnesses and injuries we see is astonishing for what most people consider a young and healthy, well-screened population. We most commonly see issues like diarrhea, bone fractures, Athlete's foot and headaches, but we occasionally have to respond to an unforeseen diabetic emergency, a non-traumatic intra-cranial hemorrhage, viral hepatitis, or acute urinary obstruction, among other things. I never know what case Spc. Kurtz is going to give me when he walks into my office after meeting the patient and gathering baseline information – which he has become quite good at! Many times he has an idea of the likely diagnosis even before he comes to find me.

After his assessment, we discuss the case together and then I finish my examination of the patient. Afterward, Kurtz performs any needed tests and then quickly fills prescriptions in our small pharmacy. While resources are limited here on the FOB, the aid station does have the ability to perform x-rays, electrocardiograms, and basic lab work.

Kurtz: Sick call is not the most fun job in the world sometimes, but it has to get done. We certainly see some interesting cases and I have definitely seen more here than back at home at Ft. Lewis. In the clinic I have seen cases of appendicitis, diabetes and even an accidental, self-inflicted stab wound. There are some patients who take precedence over others in order to save life, limb or eyesight, but the most common things I see are back pain, foot pain and cold symptoms. I usually have a pretty good idea of what someone's illness is after talking to them, especially having been here for awhile.

9:00 a.m.



U.S. Army Spc. Nkelo Kurtz, kneeling center, medic for Provincial Reconstruction Team Farah, renders aid to Spc. Domingo Recinos, PRT security force team member, during medical evacuation training on FOB Farah. (Photo by Chief Hospital Corpsman Josh Ives)

Cook: Our PRT's overall mission is to train, advise and assist Afghan leaders here in Farah, and the medical department plays a key role in that effort aside from taking care of medical needs on the FOB and providing medics for missions. While our civil affairs team and other PRT staff members might have a mission on a given day, I could also have a mission as well. I have attended meetings at the local provincial hospital with the Director of Public Health, which like our other meetings with our Afghan counterparts, are critical to our mission at the PRT. I have also attended provincial immunization council meetings and receive updates on communicable diseases in Farah through the province's public health team. Last year there were 33 recorded cases of polio in the entire country, only one of them coming from Farah. With the help of the PRT, UNICEF, WHO, USAID and other organizations, the Farahis are mak-

ing great strides to eradicate polio in the province and I'm confident they'll be able to eradicate the disease here if they continue their efforts. The PRT also funds a supplemental feeding program for children age five and under who are malnourished. Our medical team checks in each month to ensure that the program is on track, that children are receiving the proper supplements, and that preventive education classes are being offered to mothers at each visit. Basic hygiene and topics such as breast care and child development are taught.

10:00 a.m.

Cook: Several days per week we hold training sessions with the Forward Surgical Team. Topics usually include clinical practice guidelines, burn care, IV administration, pump operations and a host of other training topics to keep us on our toes and prepared for whatever comes through the door. All base medi-

cal personnel take part in the training, including our coalition partners, and there is generally a practical component to the training. For example, when learning about placing arterial lines, we pull out kits, put on gloves and practice with the equipment so that all medical personnel are familiar with the supplies and procedures to start a line.

Kurtz: The FST is where we learn the most in trauma training. It's important to know what everyone else does and what they might need in order for things to run smoothly when patients come in. It looks like a mess in the aid station and FST's area during trauma care, but it's actually controlled chaos. Everyone knows what they are doing, and if someone needs something to do their job, we work together to make sure they get it. It's really important that we work together and know each other's job to provide the best care for our patients. Some of the training we do with the



U.S. Navy Lt. j.g. Laura Cook, right, physician assistant for Provincial Reconstruction Team Farah, evaluates a wounded Afghan policeman at the aid station on FOB Farah. (Photo by Chief Hospital Corpsman Josh Ives)

FST goes over my head at first because it is designed for higher levels of care, but the providers do a good job of re-explaining things until I understand and comprehend the skill.

Always on Call

11:00 a.m.

Cook: We break for chow and after sitting to eat we're notified of three incoming category alpha traumas (alphas being the most critical level). The three incoming patients are Afghan National Army soldiers who have hit an improvised explosive device on a patrol. We quickly put down our lunch and the medics and I scurry to make sure we're ready to take patients. While they pass out gowns and gloves, I check the 9-line/MIST report (description of the casualties and injury severity) and verify their estimated time of arrival. These soldiers are coming in from the point-of-injury and will have only had basic interventions by the MEDEVAC crew. We establish our roles before they arrive

and Kurtz is assigned as medic number one, who is responsible for obtaining IV access. I'll be the lead provider at bed one in the aid station.

Kurtz: Usually when we go to pick up patients from dust-off, the helicopter comes in fast and the patients are already triaged. I pull the gator up, four people lift the patients in, the flight medic jumps in the back and we get the patient back to the aid station for treatment as fast as we can.

After the patients are searched, we work quickly to re-triage all of the patients to see who needs the most urgent care. The most critical patient goes to the Forward Surgical Team's first bed, and the other goes to bed two. We treat the less critically wounded patient in the aid station down the hall from the FST. Despite my assignment on bed one, I end up bouncing between different patients as I'm needed. There are several medics from different nations stationed on base who come help us during traumas and we work together as a team,

and across language barriers and varying levels of expertise, to provide the best care possible to our patients.

Critical Care

Cook: The two most critical patients are carried straight in to the FST, and within five minutes one of them is in the operating room. He needs surgery to open his abdomen, control bleeding, and assess damage from a shrapnel wound. In the aid station, Kurtz and I care for a young man who has sustained multiple superficial lacerations, a head injury and who also reports pain in his left cheek and left upper arm. One key person in our efforts to treat Afghan patients is our interpreter. He is critical when we work to get the patient's medical history and he also stays right near the patient's head throughout the process, to talk to him and answer his questions. As Kurtz starts an IV in his right arm, I perform a head-to-toe assessment of his condition and also run an ultrasound to check his abdomen for internal



U.S. Navy Chief Hospital Corpsman Josh Ives, left, U.S. Navy Lt. j.g. Laura Cook, center, both medical professionals with Provincial Reconstruction Team Farah, talk with Dr. Abdul Jabar, Farah Director of Public Health, right, during a key-leader engagement at the Farah City Hospital. (Photo by Lt. j.g. Matthew Stroup)

bleeding. Kurtz also monitors his vital signs. After completing my assessment, I order a tetanus shot and morphine for the soldier.

Kurtz: When more critical problems have been taken care of it's time to start taking x-rays of our patient. We only take them if we suspect that the patient has broken bones, and want to rule out any other injuries. The x-rays themselves are not that hard to shoot, though the tough part is trying to place the camera and the patient's body correctly so we get a picture of everything we need to see. Once we're done with the x-ray, we prepare the patient for transfer to a more advanced medical facility. I grab the blizzard kit, which is used to prevent the patient's body temperature from dropping, and lay everything out for transferring the patient to a new litter. Once I'm finished, we'll be able to transfer our patient.

Cook: While reviewing the x-ray we discover a fractured jaw, separated

shoulder and non-displaced fracture of the upper arm. Before we can do much more, we get word that a helicopter is on the way to pick up all three patients so they can be transferred to a facility better equipped to care for their injuries. Since we're a Role I/II facility, we don't have the capability to keep patients long-term. We stabilize them and send them to higher level of care, the Role III, which has inpatient beds and far more resources. We splint and wrap his arm, place it in a sling, clean and cover his lacerations, and after Kurtz packs the patient in a kit to keep him warm the patient is ready for transfer.

1:30 p.m.

Kurtz: The helicopter touches down and our patient, along with the other two surgical patients, will be loaded and flown to the Role III. After a couple of hours of patient care, it's time to clean up. It's very important for us to clean our equipment and have it ready for the

next patient because you never know when they'll be coming through the door. There have been times where we get one patient out the door and there's already more waiting to be dropped off at our aid station.

2:00 p.m.

Cook: After successfully sending our patients off to the Role III, my team restocks and resets our aid station – another trauma could happen at any time and it must be ready. I have a few minutes to review and complete patient notes and send emails before attending an afternoon brief.

3:30 p.m.

Kurtz: Time to go work out. As we move towards summer and the temperatures rise, I usually just hope that it isn't so hot out that I can't run more than a mile.

Cook: Time for the medical team's workout of the day/PT time. Spc. Kurtz



U.S. Army Spc. Nkelo Kurtz, right, and Spc. Nathan Krueger, left, medics assigned to Provincial Reconstruction Team Farah, assess the medical condition of an Afghan National Army soldier at the FOB Farah battle aid station. (Photo by Lt. j.g. Matthew Stroup)

loves to PT and I think this is his favorite time of day. We have to fit it in when we can due to our unpredictable schedules. We sign out on a white board so we can be found quickly if needed. Warmer weather is around the corner, so we are enjoying the last few temperate days by running outside and cooling down on the roof.

Evening Hours

5:00 p.m.

Kurtz: Time to go eat and find something that looks appetizing. After eating, I read a book or write and try to keep myself busy. Time seems to go by much faster that way.

7:00 p.m.

Cook: Back to the aid station for evening sick call hours. We have lots of folks working shifts and it's easier for them to be seen in the evenings. Kurtz and I see a case of allergic rhinitis and treat a sprained hamstring after a 2-on-2 basketball game.

8:00 p.m.

Kurtz: Time to go talk to my family if I can reach them. I also spend a good portion of my time doing school work, then relaxing and getting ready for bed. I need to make sure I rest when I can as you never know when we'll get another patient in.

Cook: Time to wind down, pick up some laundry, make a quick call to Mom, then shower and settle in with a book before calling it a day. I have to be rested for the next patient which is always just around the corner.

One Team

Cook: Our medical team works hard taking care of patients every day and many nights, whether trauma or routine illness, and works equally hard at supporting one another. Being on-call 24/7 for the duration of a deployment can be exhausting mentally and physically, which is why having a solid team is critical to our success. It is a privilege to be part of this small group of Army medics and Navy corpsmen in the aid station. This deployment is my first opportunity to work alongside another service, on

the same team, and it has been a great experience. We often compare Army and Navy terminology (Kurtz says "latrine" and I say "head") and laugh good-naturedly at our different vocabularies. I will always remember this deployment and what an honor it's been to serve with Spc. Kurtz.

Kurtz: It has been a privilege working with the Navy team. It is interesting to see how much the services differ from each other but how similar we really are. The mission comes first and then everything else after that. The vocabulary is one thing that I cannot get used to.

When I first got here someone said it was time for a muster and I asked if they wanted some mustard. I later found out that a muster is when everyone gets together in the morning to find out what has to be done that day.

Deployment has its ups-and-downs, and at this point I think everyone is ready to go and see their loved ones or go to their next assignment. This has been a good deployment and everything I've learned here I'll take with me to my next command.+

SAILORS TRAIN UGANDAN SOLDIERS

Story and photo by Marine Corps 2nd Lt. Andrew Bolla



U.S. Navy Hospital Corpsman 1st Class Brent Pope, Special-Purpose Marine Air-Ground Task Force (MAGTF) Africa corpsman from Big Piney, Wyo., congratulates a Uganda People's Defense Force (UPDF) soldier during a graduation ceremony at the Peace Support Operations Training Center-Singo in Kakola, Uganda. Marines and Sailors with Special-Purpose MAGTF Africa recently completed a logistics focused engagement with UPDF soldiers who will deploy to Somalia later this year. Since deploying in January, Special-Purpose MAGTF Africa has trained more than 800 African service members, including 310 UPDF soldiers.

Sailors assigned to Special-Purpose Marine Air-Ground Task Force Africa recently completed their second 10-week training engagement with Uganda People's Defense Force (UPDF) soldiers. While enhancing the capabilities of two UPDF logistics companies over the last six months, U.S. Navy Hospital Corpsmen First Class Hugo Canedo and Brent Pope took the opportunity to increase their own capabilities and prepare for their Fleet Marine Force qualification.

The Fleet Marine Force Enlisted Warfare Specialist Device is a qualification insignia worn by enlisted Sailors assigned to the Fleet Marine Force of the U.S. Marine Corps.

"The FMF device is a sign of distinction between you and your peers- it shows that you have knowledge that

most sailors may not even be aware of," said Canedo, a New York native.

In order to earn the right to wear the FMF device, a Sailor must serve one year with a Marine Corps unit, pass the Marine Corps physical fitness test, and complete a variety of exams that demonstrate skills such as weapons fundamentals, land navigation and combat communications.

"You study a lot, get your book signed off in the different sections, complete two tests and a selection board. If you pass all those, then you get the device," said Pope, a Big Piney, Wyo., native. "For me it will be my third device, and it's going to be the pinnacle of the three I have."

The Enlisted Fleet Marine Force Warfare Specialist designation is awarded to Sailors supporting Marine

Corps commands, usually a hospital corpsman or religious programs specialist. Pope and Canedo have spent the last six months in Uganda working with the UPDF on medical training.

"With some of the classes I taught to the UPDF, I took portions that I need to know and put them into the courses I was teaching. It definitely helped put it in my memory," said Pope.

Pope and Canedo have completed a mock oral board and now must pass a graded oral board and written exam. They have not arrived at this point on their own.

"It's not just us, everyone has been helping us along the way. It's pretty much been a group effort," said Canedo. "When there is free time on the weekends or if there is a break or lull in training, I will approach one of the guys and



U.S. Navy Hospital Corpsman 1st Class Hugo Canedo, Special-Purpose Marine Air-Ground Task Force (MAGTF) Africa corpsman from New York, speaks with Uganda People's Defense Force (UPDF) soldiers at the Peace Support Operations Training Center-Singo in Kakola, Uganda.

say, 'Hey, I'd like to go over this' and then we'll tackle that section."

The Sailors will complete the final portion of their qualification examination when they return with Special-Purpose MAGTF Africa to Marine Corps Base Camp Lejeune, N.C. For Canedo, the device will serve as a reminder of his time in Uganda.

"Whenever I see myself with that pin I'm going to go back to that time when I was here in Uganda and all the relationships and friendships that we made here," he said.

Special-Purpose MAGTF Africa strengthens U.S. Marine Corps Forces Africa and U.S. Africa Command's (AFRICOM) ability to assist partner nations. The approximately 150 U.S. Marines and Sailors conduct security force assistance, military-to-military engagements and are trained to provide support to crisis response. +



U.S. Navy Hospital Corpsman 1st Class Brent Pope, right, Special-Purpose Marine Air-Ground Task Force (MAGTF) Africa corpsman from Big Piney, Wyo., speaks with Marine Corps Capt. Dax Verdia in between training engagements at the Peace Support Operations Training Center-Singo in Kakola, Uganda.

EHR Inpatient Standardization Benefits Patients

Story and photo by Barbara Ware | U.S. Navy Bureau of Medicine and Surgery Clinical Informatics Directorate

Historically, a military patient's inpatient medical information, such as medical history, exam data, hospital visits and physician notes, were recorded inconsistently and stored on paper in multiple locations.

"The implementation of electronic health records (EHRs) allows clinicians to now look at labs, notes and test results from prior patient interactions without having to search for individual paper files or toggle between computer systems," said Lt. Cmdr. Alexander Holston, Navy Medicine East chief medical informatics officer.

But challenges remained even after the Navy's adaptation of an inpatient EHR. Problems lingered regarding inconsistency and lack of standardization in data recording. Recording medical data is important for a number of reasons. It not only allows clinicians to make important patient care decisions, but it is also needed for patient safety initiatives, regulatory compliance, billing and research to improve patient outcomes.

Today, the Navy is leading a tri-service effort to standardize the recording and analyzing of inpatient medical events and procedures. As a result, Navy and other military patients and their beneficiaries get more coordinated care, up-to-date quality measures and a potentially significant reduction in medical errors.

The Navy's journey toward leading the Tri-service effort for standardization was born out of necessity. The DoD selected the Essentris® EMR™ as the inpatient electronic medical record for all military treatment facilities (MTFs) in 2009. Soon after, each MTF started

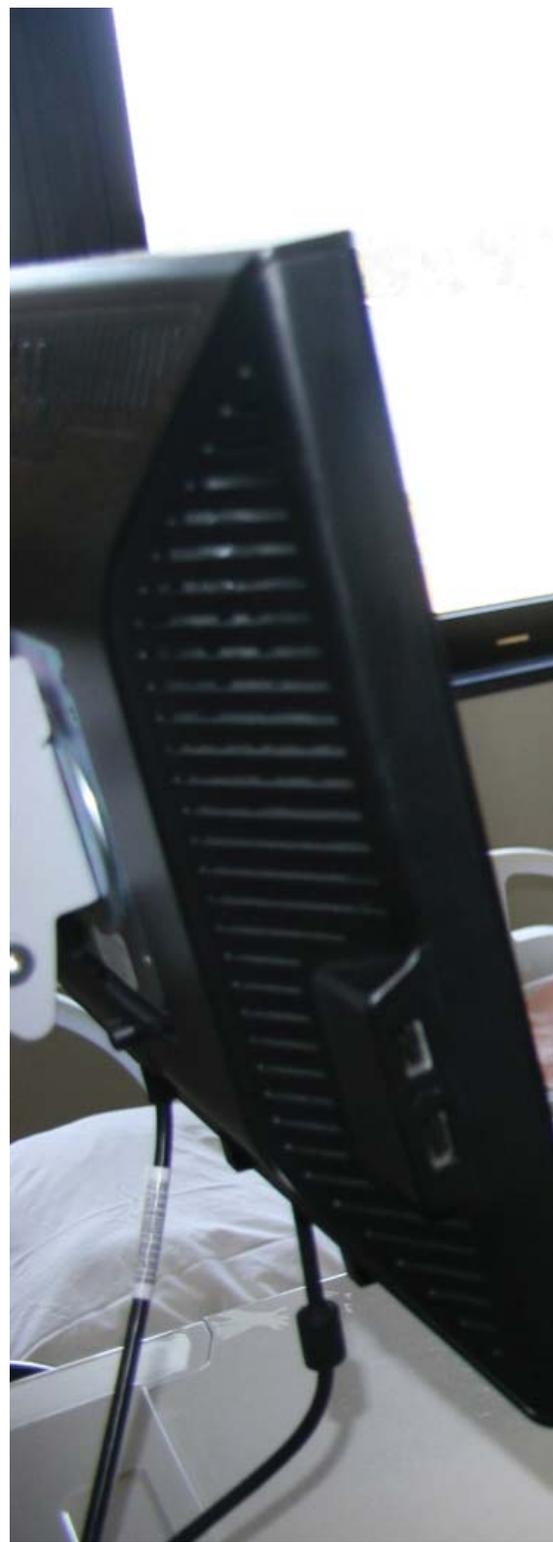
individualizing its Essentris system, which created unforeseen problems with documentation and maintenance of the software. There was no standardized way of recording information and procedures. Each MTF found itself "reinventing the wheel" when it came to creating workflows and templates.

Once standardization – implementing uniform EHR software practices across all MTFs – became a priority, the clinicians involved soon realized that it was a great opportunity to improve EHR content and patient care by adding clinical decision-making support and other features to create a more vibrant tool.

BUMED's Clinical Informatics Directorate, led by Capt. Lea Beilman, under the direction of Rear Adm. Terry Moulton, deputy chief, Medical Operations is leading this initiative, which is one of the world's largest inpatient EHR implementation and standardization initiatives. The need for clinicians and other health care staff to help with standardization led to the

Clinical Informatics Directorate creating Content Advisory Groups (CAGs) are built around functional communities, e.g. medical/surgical, perioperative and laboratory communities – those responsible for the patient's continuum of care from admission to discharge.

Today, more than 900 physicians, physician assistants, nurse practitioners, nurses, coders, medical technicians, corpsmen, dieticians, pharmacists, chaplains, lab staff, administrators, physical and speech therapists and administrators participate in the CAGs. All of the CAG volunteers work to coordinate and continuously optimize Essentris inpatient content and clinical workflows in all MTFs. Although the Navy leads the on-going standardization initiative, all CAGs have military and civilian mem-



bers from Army, Navy, Air Force and TRICARE Management Activity.

"The level of cooperation amongst the services has been outstanding," said Air Force Lt. Col. Kathleen Samuels, Air Force Medical Operations Agency. "We all share the common goal of providing the best care possible to our patients."

Among the new advances is 3D lab mapping. Capt. Cynthia Wilkerson, director, Center for Clinical Lab Medi-



Electronic health records allow clinicians to look at laboratory notes and test results from prior patient interactions without having to search for individual paper files or toggle between computer systems. (Photo by Barbara Ware)

cine and Specialty Leader to the Navy Surgeon General for Medical Technology, championed this important new lab feature. As a result, clinicians at all of inpatient facilities can view more than 150 of the most commonly ordered laboratory test results in Essentris. As a result, clinicians at all Navy inpatient facilities can view approximately 157 Labs and 160 Blood Gas test results. In addition, clinicians can now enter up to 38 Point

of Care lab results in Essentris.

Other improvements include using nationally recognized process improvement guidelines to minimize the risk of falls, ventilator acquired pneumonia, pressure ulcers and other possible negative outcomes that can occur during hospitalization.

“Standardization also allows us to include invaluable clinical tools like Operating Room Crisis Checklists for quick

access in an emergency.” said Capt. John L. Bastien, Naval Hospital Bremerton. “According to the Agency for Healthcare Research and Quality, following a checklist during these types of crises means that staff are 75% less likely to miss a critical clinical step. Clinical staff know these tools have been extensively vetted by the CAG members, so they are confident they are following the best practices available.”+



Hiro

Rear Adm. Michael H. Mittelman

Things I've learned

I was an NROTC scholarship student, so I thought I was going to be a Naval aviator. This was when the Vietnam war was winding down and I had some knee issue going on. So at that point they said, "No, you don't qualify for aviation, so would you like to do something else or you can get out." I didn't want to do anything else, so off I went and I got to go to Optometry school. Then I got a scholarship there. So I owed them four years at the time. My plan was always to give them four years. I went so far as to make a commitment to buy a practice – then the detailer called us and offered us Rota, Spain. My wife said, "While, yeah, let's go to Spain." And as they say, the rest is history.

We stayed in because of the people and because we were having fun. We always said, "As long as we're having fun and as long as they keep promoting us and giving us the appropriate challenges, we're going to stay in."

As a clinician, I never aspired to be a flag officer, because it never happened. So I was probably more shocked than most when I was selected. It's been a wonderful career of surprises.

I always wanted to be a lawyer when I was a kid, and I still do, I think. If you ask my parents they'll tell you that I always wanted to be a lawyer. I didn't quite get there, so I failed.

What got me interested in optometry was my college roommate, Jeff Praskin, whose father was an Optometrist, but not just any optometrist – Lyndon Johnson's optometrist. He brought me home one summer to his house and I saw all this neat stuff. I was always interested in physics and always good at math. So I said this looks kind of interesting and that's how I picked optometry – that was my influence.

I didn't grow up wanting to be an eye doctor. I always liked helping people – that's the best part of this. But I tell my kids, it's a means to an end.

I was at Cherry Point with the Marines. I'll never forget doing an eye exam on one of these kids. You've had an eye exam, "Which is better, one or two?" So I'm going through the exam with this kid and finally he's at that point where he can't decide between the two. I ask him again, "Which is better, one or two?" He says, "Sir, you tell me, you're the officer." The first time it happened I chuckled. But it happened about 10 times there. It was hysterical.

I was in Spain. I was the only eye provider for probably 1,000 or 2,000 miles. I had a young kid who came in with a penetrating eye injury. His sister broke a 45 record and flung it. It impaled the eye. You can do a couple things. One thing we say is not to pull it out. Unfortunately, they did. So I had several choices. But what I was able to do was save the kid's eye. I flew with the kid to Germany. That was so rewarding to be able to do things like that. That's the way my clinical career has gone. I've always considered myself a very good clinician.

My dad, in particular, who is no longer with us, he was just a really quiet guy – so insiteful. I didn't realize it then, of course, I realize it now. He taught me the ethics of life – if someone is paying you a dollar, you give them a dollar's worth of work. You do more than you are supposed to. There are two ways to do a job – do it right or do it over. My goal is you always have to pay attention to people and listen. Dad was a driving influence in my life. My mom too, because she taught me to speak my mind. Sometimes it doesn't work out too well. But my parents had a real influence on me.

I'd like to be remembered as a thoughtful, covenant leader – as someone who gave something back to the organization because I recognize the organization gave so much to me.

The men and women of Navy Medicine are the best, and don't ever forget it. They're the best trained. They come with the best organizational skills. But they also come with the best attitude. They understand what our mission is, so keep charging. I would say proceed until apprehended because they are, frankly, the A-Team and I would follow them anywhere in the world we needed to be.



Dr. Wayne Horn, third from the right, pictured with members of the Australian Navy during a collaborative research project.

In Memory of Dr. Wayne Horn

By Cmdr. Fred Yeo | Naval Submarine Medical Research Laboratory

Dr. Wayne Horn served as medical director of the Naval Submarine Medical Research Laboratory (NSMRL) from 1999 to 2013. Horn was the Navy's lead for submarine disaster survival, escape and rescue and a recognized international expert in the field. His achievements are unrivaled and have transformed the field of submarine escape and rescue from that of no potential for escape and survival to that of successful escape and prolonged survival from depths of greater than 600 feet.

Horn represented the United States at NATO submarine escape and rescue conferences, wrote international standardization agreements, developed the blueprints (Guard-Books) for submarine escape, designed and tested the submarine escape suit, developed long-term submarine survival sustainment solutions, and was the driving force to reinstitute pressurized submarine escape training into the submarine force. He was instrumental in developing medical standards for the safe integration of women into submarines and conducted several congressionally mandated research studies on the issue of the effects of submarine service on women's reproductive health.

Horn was born in the Panama Canal Zone in 1947 to Edgar and Lois Horn and settled with his family in Bossier

City, Louisiana. It was in Louisiana that he discovered his love of books and science and was rarely seen without a book in his hand. In junior high school he met Frieda Cogburn, who would go on to become his wife of 44 years. Horn earned his undergraduate degrees in chemistry and microbiology from Northwestern State University. In 1969 he received his Naval Commission as an unrestricted line officer and served on the minesweeper USS Prime (AM-466) and the Air Craft Carrier USS Oriskany (CV-34). After his Vietnam service, he worked as a product engineer at Western Electric, where he perfected the coin-collecting mechanism of the pay phone, and briefly for the U.S. Geological Survey as an offshore oil-rig inspector. After this period in industry, he entered medical school at Louisiana State University and received his M.D. Following this, Horn completed a family practice residency and practiced in the private sector for 10 years prior to re-entering the military in 1991. He completed Undersea Medical Officer training and was assigned to submarine squadron 10, King's Bay, Georgia, and earned his Submarine Warfare Qualification. He went on to serve as SMO at the elite submarine development squadron DEVRON-5, where he began to have a significant impact on submarines and submariner health.

Horn envisioned and initiated the Disabled Submarine Entry Team, which allowed for integration of various rescue elements, the Deep Submergence Rescue Vehicle, and the Submarine Rescue Chamber with the medical support element on the surface. His pioneering efforts were shared with most other Navies of the world, resulting in a coordinated robust concept of operations for submarine rescue missions worldwide.

In 1999, he moved to Groton and served the remainder of his career as the Medical Director at NSMRL. During this period, he wrote more than 25 peer-reviewed medical articles and 30 technical reports, was part of more than 50 research projects, directed the first at-sea submarine survival exercise, conducted research on carbon dioxide removal technology, performed women's health monitoring studies to address reproductive health concerns for women serving on submarines, and was instrumental in the cessation of smoking on board submarines.

Horn's lifelong contributions to the health and welfare of submariners will have immeasurable impact on generations of future submariners. Successful escape of submariners from a disabled submarine is only possible today thanks to Horn's commitment, ingenuity and dedication. He passed away June 4, 2013. +

Researchers Evaluate In-Mask Hypoxia Mitigation Sensors

By Dr. Jeffrey Phillips and Dr. Bill Becker | Naval Medical Research Unit-Dayton

Hypoxia represents a significant hazard in military and civil aviation. Since 2001, over one hundred hypoxia-related hazard reports and three mishaps in Naval aviation have been attributed to hypoxia.

Scientists and engineers at the Naval Medical Research Unit Dayton (NAMRU-Dayton) are testing in-cockpit hypoxia detection methods focusing on physiological sensors including pulse oximetry, reflectance oximetry, and near-infrared spectroscopy. Although each of these techniques is capable of detecting a hypoxic event, their functionality is often compromised by environmental factors and require the operator to experience a significant degree of blood oxygen desaturation before hypoxia is detected.

These limitations led NAMRU-Dayton investigators to seek hypoxia detection methods that would rapidly alert the operator to the onset of a hypoxic event.

One promising approach uses gas sensors to monitor the volume and quality of air provided to pilots and crew through their life support systems. Researchers determined that in the event of a hypoxic episode an oxygen sensor in the mask would detect hypoxia up to six minutes before any of the measures of blood oxygen saturation would.

These promising results have led to a collaboration between the Navy, Air Force, and private industry. An industry partner developed a sensor suite to detect any disruption in the quantity or quality of the breathing air supplied to the pilot. The suite is composed of an oxygen and flow sensor to test air before it reaches the operator as well as a carbon dioxide sensor to check for anomalies in expired air to suggest a disruption to normal respiratory metabolism.

NAMRU-Dayton researchers are working on a project, funded through the Air Force Surgeon General's Office, to characterize the effect of normal aerospace environmental factors on sensor performance and accuracy.

Many aspects of the aviation envi-



The orbital hypoxia mitigation sensor suite mounted to a standard aviation mask.
(Photo courtesy of Naval Medical Research Unit Dayton)

ronment, such as fluctuating barometric pressures and humidity levels as well as temperature extremes, can negatively influence sensor performance in operational settings.

These sensors are evaluated inside a hypobaric chamber while temperature, pressure, flow and humidity are manipulated. The results will be used to establish algorithms to correct for the negative effects of aviation-specific environmental issues.

NAMRU-Dayton researchers and

their research collaborators will continue investigating this and other potential mitigations with the constant goal to improve the safety of flight for our warfighters.

NAMRU-Dayton conducts research in the areas of acceleration effects, aviation medical standards and personnel selection, physiological and cognitive effects of altitude, vision research, pulmonary health effects, neurotoxicology, neurobehavior, reproductive health and systems biology.

These sensors are evaluated inside a hypobaric chamber while temperature, pressure, flow and humidity are manipulated.

NAMRU-3 Staff Collaborate with Visiting DIMO Training Team



Dr. Atef El Gendy, Naval Medical Research Unit No. 3 (NAMRU-3) Bacterial and Parasitic Disease Research Program, attends a Defense Institute for Medical Operations presentation with Egyptian Army health professionals. (Photos courtesy of NAMRU-3)

From Naval Medical Research Unit No. 3 Public Affairs

Staff members from the U.S. Naval Medical Research Unit No. 3 (NAMRU-3) collaborated with a visiting Defense Institute for Medical Operations (DIMO) training team to present a short program to promote health care among the Egyptian military. Dr. Atef El Gendy of the NAMRU-3 Bacterial and Parasitic Disease Research Program worked closely with the five-member DIMO team to provide scientific presentations and serve as a scientific translator during the two-week training session. The emphasis on this trip was infection control and communicable disease prevention. The training course was held at the Egyptian Armed Forces Medical Complex in Kobry El Qobba, Cairo.

In April, the DIMO team provided two courses to Egyptian military medical staff - (1) Infection Control, Hospital Epidemiology and Medical Waste Management: Local and National Program Development, and (2) Avian/Pandemic Influenza Infection Control and Hospital Planning for Pandemic



The Defense Institute for Medical Operations team poses for a photo with Egyptian Army health professionals.

Management.

Gendy, who is a microbiologist, gave presentations on sampling planning for clinical specimen collection and transportation of infectious substances and the role of the clinical microbiology laboratory in infection control programs and during disasters.

Following the training, the Egyptian military's Infection Control Program consultant, Dr. Shereen El Masry, requested laboratory training at NAM-

RU-3 for the Kobry Elkoba Military Hospital laboratory staff.

DIMO is a dual service agency with representatives from the Air Force and Navy who provide world class, regionally focused health care education and training to partners around the world. A small facilitating agency that utilizes subject matter experts throughout DoD to develop curriculum and teach courses around the world, DIMO brings people of various countries together to establish a common base of understanding among dedicated health care professionals. Specific emphasis on building international health care bridges, disaster preparedness, communicable disease prevention and other current health care issues provide a unique opportunity for the Air Force and Navy to contribute to coalition partnerships.+

The emphasis on this trip was infection control and communicable disease



People watch as the Peruvian Navy launch a new military ship in Mazan, Peru, called the Rio Napo. (Photo courtesy of Naval Medical Research Unit, No. 6 Public Affairs)

NAMRU-6, Peruvian Navy Provide Support to Amazon Frontier

By Lt. Carlo Traverso | Naval Medical Research Unit No. 6 Public Affairs

The Peruvian Navy launched a new military ship (B.A.P.) in Mazan, Perú, called the Rio Napo as part of the country's Sustainable Mobile Platform for Social Action. The ship's mission is part of an ambitious new national program to bring governmentsponsored services such as health care, education and banking to isolated populations along the tributaries of the Amazon River.

During the launch, a "telemedicine" component displayed its capabilities in the use of medical information exchanged from one site to another via electronic communications to improve patients' clinical health status and diagnostics. The demonstration involved the Peruvian Naval Hospital (CEMENA), Walter Reed National Military Medical Center (WRNMMC), and the new Peruvian Navy river ship B.A.P. Rio Napo on the Napo River.

The commanding officer of the U.S.

Naval Medical Research Unit, No. 6 (NAMRU-6), Capt. David Service, coordinated the military-to-military phase of the demonstration and briefed the U.S. Ambassador to Perú, Rose Likins; Deputy Chief of Mission, Mr. Michael Fitzpatrick; and the U.S. Political-Military Advisory Committee on the final plan for U.S. support to the video teleconference (VTC) and telemedicine demonstration with the Peruvian Navy. The President of Perú, Ollanta Humala; Minister of Defense; Minister of Health; and military VIPs were all in attendance to observe the international VTC during the vessel's commissioning ceremony.

The "telemedicine" event demonstrated the ability of the Peruvian Navy to communicate and consult with specialists from other countries and other areas of Perú. In addition to helping establish the communications link,

NAMRU-6 provided technical training and equipment to the embarked Peruvian medical staff to assist with disease recognition and diagnosis.

NAMRU-6 was instrumental and a key player in establishing coordinated telemedicine connectivity and medical consultations with WRNMMC to help the Peruvian Navy succeed in this vital endeavor.

Led by Service, NAMRU-6 coordinated all aspects of the VTC and telemedicine consultation and also provided laboratory training and equipment for the inaugural voyage of this new class of ship. Immediately following the christening ceremony and telemedicine demonstration, Peruvian President Humala and U.S. Ambassador Likins traveled to Washington D.C. to meet with President Obama and Secretary of Defense Chuck Hagel for planned bilateral defense talks. +

HISTORY OF WHEELCHAIR BASKETBALL

By André B. Sobocinski | U.S. Navy Bureau of Medicine and Surgery Historian



Naval Hospital Corona, Calif., was a crown jewel of Navy Medicine in the 1940s. A former luxury resort for Hollywood stars, the U.S. Navy purchased it in 1941 by order of President Franklin Roosevelt for use as a hospital. Indoor spas that had once pampered Hollywood's elite were now used as "hydrotherapy treatment centers" for Sailors and Marines; the resort's luxurious bedrooms were now saved for the many thousands of war veterans recuperating from wounds and illnesses. The hospital had a carpentry shop, an art studio, and

a "toy factory" where men, physically and psychologically damaged by the war, could repair their weary minds and bodies through arts and crafts. Corona also boasted a world-class gymnasium that was used for rehabilitative activities and from where the newest adaptive sport of wheelchair basketball would take off.¹

Today, wheelchair basketball is a mainstay of competitive sporting tournaments like the Warrior Games, and the Paralympics, and played by an estimated 100,000 men and women across the globe.² Although sources differ on specifically when it was first developed, all agree it was born in the wake of World War II and first played exclusively by wounded veterans. In her

article, "Miracle of Ramp C," Hildegard Level credits Robert Ryneanson, an assistant athletic director of special services at Birmingham Veterans Administration (VA) Hospital in Van Nuys, Calif., as the game's originator.³ It was at Birmingham's gymnasium in March 1946 that a Navy physician, Lt. Cmdr. Gerald Harry Gray first saw basketball used as a diversion and physical therapy for paraplegics. Inspired by the game's potential, Gray set out to create a competitive team that would both inspire the legions of disabled veterans and become a symbol for the budding recreation.⁴ The result would be Naval Hospital Corona's "Rolling Devils," a basketball team comprised of World War II

CHAIR BASKETBALL



Marines and Sailors who had suffered paralysis through accidents, combat injuries, and polio. Leading Gray's Devils on the court was a 31-year old Marine colonel⁵ and former triple-threat athlete named Johnny Winterholler.

It's been said that Johnny Winterholler was an "athlete's idea of an athlete, and a coach's answer."⁶ An All-American in baseball, basketball and football at the University of Wyoming, Winterholler could easily have turned pro when he graduated in 1940. So it was a surprise to many classmates and professional sport teams when Winterholler decided to obtain a commission in the Marine Corps in June 1940. Following Marine Basic School in Philadelphia, and a

It's been said that Johnny Winterholler was an "athlete's idea of an athlete, and a coach's answer."



“The Rolling Devils,” American wheelchair basketball pioneers. Former All-American athlete and POW Johnny Winterholler can be seen fifth from the right. (Photo courtesy of Elizabeth Kinzer O’Farrell)

tour of duty at Marine Corps Base San Diego, Winterholler was sent to the Philippines where he would become one of the five thousand men and women defending the islands against a Japanese invasion in early 1942.

When the defenders heroic last stand ended in Corregidor in May 1942, Winterholler was taken prisoner of war (POW). He would spend the next 24 months suffering agonizing abuses and dietary deprivations at prison camps in Bilibid, Cabanatuan, and in Mindanao. In March 1944, as he slowly wasted away, his fight for survival nearly came to an abrupt end when the weakened blood vessels in his spinal column spontaneously ruptured causing immediate paralysis below the waist. Until the prison camps were finally liberated in February 1945, Winterholler would spend his remaining days sprawled on a stretcher fending off ants and starvation while developing dangerous bed sores.

When Gray first met Winterholler at Naval Hospital Corona in 1946, he

saw a man, who despite his hardships, was imbued with a “natural bounce and contagious enthusiasm.” Gray knew instantly that the Marine would be able to spark others with similar physical disabilities.⁷ With Winterholler on board as team captain, Gray began to establish regular practices at Corona. Soon after, Gray began arranging exhibition matches where the Devils would play newly formed VA hospital teams. They would even play against able-bodied amateur and semi-professional basketball players who would handicap themselves in wheelchairs for the duration of the contest.⁸

By 1947, the Winterholler-lead Devils were something of sports sensations. One reporter wrote that the Devils were “probably the greatest wheel chair operators in the world. It is amazing the speed they can muster, while moving their vehicle with one hand and waiting for a basketball pass with the other.”⁹ Winterholler the athlete was being dubbed by the national press as the “demon

on wheels,” “spider,” and the “accurate shooting colonel.”¹⁰

By 1949, in large part to the Devils, wheelchair basketball had expanded beyond hospital settings. It had become a serious competitive sport played by a host of homegrown teams with such colorful names as the “Bulldozers,” “Gizz Kids,” and “Rolling Pioneers.” Owing to the sport’s newfound popularity, Dr. Tim Nugent, head of the Student Center of Rehabilitation at University of Illinois, organized the first National Wheelchair Basketball Tournament in 1949.¹¹ Later that year, Nugent united the six-tournament teams under a National Wheelchair Basketball Association (NWBA). Today, the NWBA consists of 181 basketball teams and 22 conferences.¹²

Postscript

Despite their roles as pioneering flag-bearers of wheelchair basketball, the Rolling Devils would fade into obscurity as team members left the hospital to begin new lives. By 1948, Dr. George



A practice game at Naval Hospital Corona. (Photo courtesy of Elizabeth Kinzer O'Farrell)

Gray, a naval Reservist, would return to his private practice in Oakland, Calif. In June 1947, Col. Johnny Winterholler, married with two children, moved to Los Angeles to become a Certified Public Accountant. In 1949, he moved to Oakland, Calif., where he obtained a job as office manager in George Gray's medical practice. He would later be inducted in the University of Wyoming Athletics Hall of Fame and in 2008 become a namesake for the Lovell High School gymnasium in Lovell, Wyo.

Footnotes:

1. Sobocinski, André. "Book Review: *The Norconian Resort* by Kevin Bash and Brigitte Jouxte." *Navy Medicine Magazine*. March-April 2008. P34

2. "History of the Game." *International Wheelchair Basketball Federation Website*. <http://www.iwbf.org/index.php/the-game/history>

3. According to Level, Rynearson established wheelchair basketball for patients at the Veterans Administration Hospital in 1946. Level, Hildegard. "The Miracle of Ramp C." *Hygeia*. September 1949. p626.

4. Norman, Phil. *Devils Muster Speed Aplenty Cavorting in Wheelchairs*. *The Oakland Tribune*. Monday, May 12, 1947. No 132, C14.

5. Winterholler was commissioned as Second Lieutenant in June 1940 and was periodically promoted while a prisoner of war. He retired on Dec. 1, 1946 as a Lieutenant Colonel and then received further promotion as a full Colonel after received the Silver Star.

6. Gray, Gerald. *Whatever Happened to Johnny Winterholler? Those Good Years at Wyoming U.* (Ralph Edwin McWhinnie, editor). Casper, WY: *Prairie Publishing Co.*, 1965. pp236-239.

7. *Ibid.* p240.

8. The Devils played against University of California at Berkeley, St. Mary's College, as well against the organized Oakland Bittner and Sacramento Stars basketball teams. In 1947, the Devils would compete in the College All-Star World Championship held in Chicago, IL.

9. Norman, Phil. "Devils Muster Speed Aplenty Cavorting in Wheelchairs." *The Oakland Tribune*. Monday, May 12, 1947. No 132, C14.

10. Gray. p240.

11. Labanowich, Stanley. *Wheelchair Basketball: A History of the National Association and an Analysis of the Structure and Organization of Teams*. PhD Dissertation. University of Illinois at Urbana-Champaign, 1975.

12. "History of the National Wheelchair Basketball Association." *National Wheelchair Basketball Association Website*. <http://nwbahof.org/NWBAHistory.cfm>. +

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