

# *Navy Medicine*

January-February 2008



**Navy Medicine back on Iwo Jima**

# NAVY MEDICINE

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**Cover:** Mount Suribachi, Iwo Jima. Videographer Michael May (left), Director Thomas Webster (right) of Navy Medicine Support Command, Visual Information Directorate, and Navy Medical Department Historian Jan Herman shoot a scene for the Bureau of Medicine and Surgery's "Navy Medicine at War" series. BUMED will shortly release the fifth installment of the series which recounts Navy medicine's participation in the World War II Pacific campaign. Story on page 22. Photo by CAPT David Lane, MC, USN, III MEF Surgeon.

Online issue of *Navy Medicine* can be found at:  
<http://navyhistory.med.navy.mil/Publications/NavyMedicineMagazine.html>

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*Navy Medicine* considers for publication photo essays, artwork, and manuscripts on research, history, unusual experiences, opinion, editorials, and professional matters. Contributions are suitable for consideration by *Navy Medicine* if they represent original material, have cleared internal security review, and received chain of command approval. An author need not be a member of the Navy to submit articles for consideration. For guidelines on submission, please contact: Janice Marie Hores, Managing Editor, Janice.Hores@med.navy.mil or 19native47@verizon.net

*Navy Medicine* is also looking for book reviews. If you’ve read a good book dealing with military (Navy) medicine and would like to write a review, the guidelines are:

- Book reviews should be 600 words or less.
- Introductory paragraph must contain: Book name by author. Publisher, city, state. Year published. Number of pages.
- Reviewer ID: sample:

CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.  
I look forward to hearing from you.

## Admiral's Call

During December, I and my official party traveled to the U.S. Central Command (CENTCOM) and U.S. European Command (EUCOM) Areas of Responsibility (AOR). The main reason for our trip was to convey my sincere appreciation for the outstanding work the active duty and reserve service members perform each and every day. Because of the challenging conditions they experience to perform their duties we wanted to know how Navy medicine leadership can provide better support.

The first stop was Bahrain, the home of U.S. Naval Forces Central Command (NAVCENT), the Naval Component Commander for CENTCOM. We wanted to get a strategic view of the medical presence and services Navy medicine provides to U.S. and coalition forces in the Arabian Gulf, Red Sea, Gulf of Aden, and parts of the Indian Ocean.

While there we visited the Bahrain Defense Force Royal Medical Services, which provides Level IV medical care to service members assigned to NAVCENT and Naval Support Activity (NSA) Bahrain.

From Bahrain our next stop was Camp Arifjan, Kuwait, the home of U.S. Army Central (USARCENT), the Army component commander for CENTCOM, and the Army's First Theater Sustainment Command (TSC). TSC provides joint theater focused logistic support in the CENTCOM AOR, making Camp Arifjan the logistical command and control hub for Operation Iraqi Freedom and Operation Enduring Freedom.

Camp Arifjan is also home to the 44-bed U.S. Military Hospital Kuwait staffed by the Expeditionary Medical Facility-Kuwait (EMF-K). The hospital provides complete resuscitative surgery and acute care to approximately 20,000 coalition forces in five installations in the Kuwaiti Theater of Operations. It is housed in Base-x modular shelters tailored to meet the medical mission. EMF-K boasts an operating room in a tent and a state-of-the-art digitized, computerized CAT scan machine in a large metal box. It also houses mobile units of six ICU beds (expandable to 12) with full cardiac monitoring and ventilator capability.

During 2007, EMF-K conducted over 80,500 outpatient visits, 1,200 surgeries, 15,200 dental encounters, and 22,500 immunizations. This output is similar to family practice teaching hospitals and is similar in terms of breadth and depth of talent.

I met providers like cardiologist, LCDR Gautam Nayak, whose experience as a cardiologist is truly comprehensive and diverse. I also thanked the 350 plus medical personnel who have come from all corners of the globe. They represent a full spectrum presence from nearly 30 military health care facilities. This total team presence is an interesting phenomena since this hard-charging EMF comprised of several diverse specialties has come together as a cohesive and tight-knit group. This camaraderie doesn't just happen by itself; this is

a result of quality leadership and professionalism not only from the senior level but also down to the junior corpsmen. And the laudatory compliments are echoed loud and clear from the entire Army staff as well as the Navy fleet in the Arabian Gulf and Gulf of Oman. EMF-K also serves as a MEDEVAC destination for Level III care. In this role, EMF-K plays a vital part in supplying and sustaining combat operations.

From the EMF-K we flew to Camp Buehring, only 15 miles from the Iraq border. Camp Buehring serves as the last training and staging base for tens of thousands of Iraq bound troops. The 30-member troop medical clinic (TMC), working under the command and control of Medical Treatment Facility (MTF) Kuwait, is providing outstanding primary medical care to approximately 20,000 soldiers, a number that can vary depending on the deployment and redeployment of forces. The TMC at Buehring also goes in harm's way by delivering frontline medical care directly to the detachment guarding the Iraqi/Kuwaiti border in Camp Udari. EMF-K is not only sustaining the war effort (through ARCENT and TSC) but also sustaining the war fighter.

The CO, CAPT Kevin Moore, and I had the unique opportunity to drive into Kuwait City to visit the state-of-the-art Hadi Clinic, a private hospital in Kuwait. Once again, I personally thanked the host nation hospital leadership for providing stellar Level IV medical care such as neurology, MRI, and specialized lab work to the war fighters stationed at Camps Arifjan, Buehring, and several other military installations located throughout Kuwait. The level of care our warriors are getting in Kuwait is outstanding. The fact that they can get supplemental state-of-the-art medical care from the host nation brings medical care to another level.

Meanwhile back in Camp Arifjan, the Director of Medical Resources, Plans and Policy, RDML Mike Mittelman, and FORCM Laura Martinez toured the Warrior Transition Mall, Forward Deployed Preventive Medicine Unit (FDPMU), currently serving as the public health services for Kuwait, and the Warrior Return Unit. Offered to all Navy individual augmentees (currently over 14,000 in the CENTCOM AOR) returning from Iraq or Afghanistan, the Warrior Transition Mall gives sailors 3-5 days to acclimate from combat operations. During this period of "decompression," the multi-disciplinary team of mental health providers and chaplains can pre-screen our warriors for any mental health issues before they return home.





**Camp Buehring, Kuwait. VADM Robinson answers questions during an admiral's call for medical personnel. Photo by MC1 Cindy Gill, USN**

Psychological health and fitness must be placed on an equal footing with physical health and fitness. We have a responsibility to effectively identify and treat all psychological health conditions and ill effects of war, and we are committed to accomplishing that through a consistently excellent standard of care across Navy medicine.

Transporting injured troops in Iraq resembles a joint-service conveyor system. It starts with a helicopter evacuation from the battlefield by an Army Blackhawk unit that can transport up to seven patients at a time. Transport takes less than 25 minutes from battlefield to Balad, an Air Force hospital, 60 miles north of Baghdad.

Our wounded warriors normally spend about 48-72 hours in Balad. Then, if they need further care, they are transported via an Air Force C-17 Globemaster to Landstuhl Regional Medical Center.

Our tour of Navy medicine in the field followed a similar path to the one taken by the wounded. We flew to Landstuhl, Germany, to visit the Navy Expeditionary Medical Unit (NEMU) and the Deployed Warrior Medical Management Center (DWMMC) to see how Navy medicine can continue to accommodate the seriously wounded service members.

Similar in size to EMF-Kuwait, nearly 360 Navy personnel are deployed to Landstuhl Regional Medical Center (LRMC), playing a critical role in the intensive care, orthopedics, radiology, psychiatry, culinary support, chaplain services, surgical specialties, and staffing the DWMMC. Comprised mostly of volunteer reservists, they represent the second year of Reserve support mobilized for casualty care in LRMC.

DWMMC ensures all service members who become ill or are injured in theater are properly and closely followed through casualty management. The team tracks patients' medical evacuations, monitors departures from theater op-

erations, records medical information before patients arrive, meets them when the MEDEVAC helicopter lands at Landstuhl, and ensures everything is set up to accommodate the patients--from billeting to meals and medical appointments as well maintain and provide aggregate big picture information.

LRMC has over 1,100 civilian, Army, and Air Force personnel working side-by-side with our shipmates in a jointly functional approach to casualty care. Bringing all three services together in one medical facility brings some of the differences in the use of terminology and medical personnel among the three services to the forefront. However, all differences in culture disappear at the interface with the continuum of care provided for our wounded warriors. This continuum of care is patient and family-centered and is a concept upheld and embraced by all branches of military medicine.

Providers have trained their entire careers to take care of the wounded and are treating the wounded normally within 1-3 days of being injured.

Approximately 40 percent of the wounded return to duty (most in Iraq and Afghanistan, but others in Djibouti or Kosovo) after a 2-week stay at Landstuhl. If their injuries preclude return to their units, service members are flown back to the United States within days of injury.

Medicine is universal and the Navy has stepped up to the plate to serve jointly. We need to be collegial, maintain solidarity, support each other, and be willing to "step into the breach" wherever that may be to successfully conduct and complete our missions. Navy medicine is answering the call of senior leadership and the Force Health Protection (FHP) mission. 



**Camp Buehring, Kuwait. LCDR Gretchen Riss accompanies VADM Robinson on a tour of the camp's Troop Medical Clinic. Photo by MC1 Cindy Gill, USN**

## Department Rounds

### Navy Environmental Health Center Changes Name

The command at the center of Navy medicine's public health efforts has a new name. The Navy Environmental Health Center is now officially the Navy and Marine Corps Public Health Center, or NMCPHC.



NMCPHC, known as "the public health center," has always incorporated both Navy and Marine Corps components. The new name more appropriately captures the global nature of the command's public health mission, said CAPT Bill Stover, NMCPHC commanding officer.

"We have provided public health expertise to Navy and Marine Corps activities, public health professionals and communities since our inception, but our name never made the connection clear," said Stover. "Our new name is intended to make our connection to our customers more intuitive, and thereby strengthen our relationship."

According to Stover, "Environmental Health" is a term that is not commonly used, and is not well understood by customers.

"Public Health is used in the United States and around the world to describe activities and professionals who are involved in preventing disease by controlling their sources, promoting health and wellness, and monitoring populations to detect changes in their health status and to recommend interventions preserve health," said Stover. "Our name now reflects what our 250 public health professionals do every day for the Navy and Marine Corps."

The public health center is headquartered in Building Three on the Naval Medical Center Portsmouth campus in Portsmouth, VA.

For more information on Navy public health programs, visit the Navy and Marine Corps Public Health Center web site at <http://www-nmcpHC.med.navy.mil>. 

**—Navy and Marine Corps Public Health Center Press Release.**

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### DOD Announces Defense and Veterans Affairs Collaborative Disability Evaluation System Pilot

The Department of Defense (DOD) and Department of Veterans Affairs (VA) implemented a pilot test for disability cases originating at the three major military treatment facilities in the national capital region. This pilot will run for 1 year. The leadership of DOD and VA will review pilot

progress during this period to assist in determining when the program can be expanded to other locations.

The pilot will test a new DOD and VA disability system. The pilot will be a service member-centric initiative designed to eliminate duplication and often confusing elements of the two current disability processes of the departments. Key features of the DES pilot include one medical examination and a single-sourced disability rating. One goal of the pilot is to enable service members to more effectively transition to veteran status and provide them with their VA benefits and compensation.

The DOD and VA are examining the continuum of care they provide from the point of injury through rehabilitation to community reintegration. The objectives of the pilot are to improve the timeliness, effectiveness, and transparency by integrating DOD and VA processes, eliminating duplication, and improving information provided to service members and their families.

The pilot process has been developed over the last several months and is focused on recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terrorism Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (the Dole/Shalala Commission), and the Commission on Veterans' Disability Benefits.

To ensure a seamless transition of our wounded, ill, and injured from the care, benefits, and services of DOD to the VA system, the pilot will also test enhanced case management methods and identify opportunities to improve the flow of information and identification of additional resources to the service member and family. As soon as the service members in the pilot transition from the military, the VA is poised to provide benefits and compensation to these veterans.

The scope of the pilot includes all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing from the point of service member referral to a military department medical evaluation board to the point of compensation and provision of benefits to veterans by the VA.

The pilot is part of a larger effort to improve care and services to our wounded, injured, and ill. Some of the other ongoing initiatives include improved information technology and data sharing, facility enhancements, revision of benefits, new methods to care for brain injuries, and mental health concerns including post-traumatic stress disorder and the use of life-long care plans to fully support wounded, ill, and injured service members from recovery through rehabilitation to community integration. 

**—DOD Press Release, 10 December 2007.**

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## DOD Establishes Center of Excellence to Address Traumatic Brain Injury and Psychological Health

The Defense Center of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI) began initial operations 30 November. The DCoE will be fully functional by October 2009. It is currently operating in temporary office spaces in Rosslyn, VA, as part of its initial phase.

The Department of Defense (DOD), with support from the Department of Veterans Affairs (VA), is leading a national collaborative network to advance and disseminate PH/TBI knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the urgent and enduring needs of warrior families with PH and/or TBI.

“The center will integrate quality programs and advanced medical technology to give us unprecedented expertise in dealing with psychological health and traumatic brain injuries,” said Assistant Secretary of Defense for Health Affairs Dr. S. Ward Casscells. “In developing the national collaborative network, the DCoE will coordinate existing medical, academic, research, and advocacy assets within the services, with those of the VA and Health and Human Services, other federal, state, and local agencies, as well as academic institutions.”

The Defense and Veterans Brain Injury Center (DVBIC) is now integrated into the center. DVBIC has DOD’s primary subject matter expertise on TBI and many of its functions are transitioning to the DCoE. The DOD Center for Deployment Psychology, currently at the Uniformed Services University of the Health Sciences, is also integrated into the training and education functions of the DCoE.✍

*—U.S. Department of Defense, Office of the Assistant Secretary of Defense (Public Affairs) News Release.*

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## TRICARE Coverage is Guaranteed for Beneficiaries

TRICARE Management Activity wants to reassure its beneficiaries that none of them are at risk of losing their TRICARE coverage, regardless of the cost of their care or other conditions that might affect commercial insurance policies.

“I want to remind our beneficiaries that TRICARE is an entitlement earned by military service,” said MGEN Elder Granger, Deputy Director, TRICARE Management Activity. “They shouldn’t worry as their entitlement to care is statu-

tory. No contractor can simply drop the healthcare coverage of our beneficiaries.”

Beneficiaries may have seen recent news reports alleging that health insurance company Health Net Inc., rewarded its senior analyst in charge of cancellations for exceeding annual targets for revoking policies. Because Health Net Federal Services is one of TRICARE’s managed care contractors, TRICARE beneficiaries might think they are also at risk of cancellation or revocation of their TRICARE coverage. TRICARE leaders say that is simply not true. Health Net Inc., has many divisions. The issue in the news report involves the civilian commercial health insurance portion of Health Net Inc., and is not related to the Federal Services part of the company.

Unlike some commercial insurance policies, TRICARE benefits are not limited by such things as pre-existing conditions or failure to report health information. If a person is entitled to care under the laws established by Congress, then they receive that care.

“In addition to the best available medical care, we want TRICARE to offer one other benefit,” MGEN Granger said. “Peace of mind.”✍

*—TRICARE Press Release, 3 December 2007.*

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## Using TRICARE Dental Program Overseas Now Requires Command Sponsorship

As of 3 December, TRICARE Dental Program (TDP) enrollees who live overseas must be command sponsored in order to receive the overseas TDP cost-share benefits. If a TDP enrollee is not command sponsored, he will be responsible for the same cost-shares as beneficiaries living in the United States.

Before this announcement, TRICARE paid cost-shares and other out-of-pocket expenses for many TDP dental services for all TDP enrollees living outside the continental United States. But paying for TDP cost-share benefits for non-command sponsored family members was inconsistent with other TRICARE programs and Defense Department policy.

In accordance with that policy, non-command sponsored TDP enrollees who receive dental care overseas will now be responsible for these cost-shares as well as any difference between the dentist’s charge and dental contractor United Concordia’s allowances for treatment.

Determination of a TDP enrollee’s command sponsored status is based on their enrollment in either the TRICARE Overseas Program Prime or TRICARE Global Remote Overseas program as reflected in the Defense Enrollment Eligibility Reporting System (DEERS).

Beneficiaries who have questions about this policy can contact United Concordia for more information, at 1-888-418-0466 or [oonus@ucci.com](mailto:oonus@ucci.com).✍

*—TRICARE Press Release, 9 November 2007.*

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## New Website Allows TRICARE Beneficiaries to Manage Healthcare Information from Home

TRICARE prime and prime remote beneficiaries in the United States, including Hawaii and Alaska, can enroll online with the new beneficiary web enrollment (BWE).

“The new online system may be one of TRICARE’s most convenient tools to date,” said MGEN Elder Granger, deputy director, TRICARE Management Activity. “Beneficiaries can manage some of their healthcare information from the comfort of home 24 hours a day, 7 days a week.”

Prime and Prime Remote beneficiaries can log on to <https://www.dmdc.osd.mil/appj/bwe/> to enroll, disenroll, choose primary care managers (PCM), transfer regions, update personal information, add other healthcare information, and request enrollment cards. BWE allows standard beneficiaries to update personal information, add other healthcare information, and enroll in Prime.

BWE’s link to the Defense Eligibility Enrollment Reporting System (DEERS), allows beneficiaries to update their personal information for both TRICARE and DEERS at the same time. Sponsors and family members can access their TRICARE information by using their Common Access Card (CAC), Defense Finance and Accounting Service (DFAS) “myPay” Personal Identification Number (PIN), or Family Member Account PIN.

Enrollments and PCM changes are pending until approved and approval may take up to 6 calendar days. Beneficiaries can logon to the site to view the status of their account anytime and can cancel pending enrollments and/or PCM changes within 48 hours of initiating the transaction.

To date, the U.S. Family Health Plan, a TRICARE Prime option, is not available for enrollment on the BWE website.

In addition to the new web service, enrollment forms are still available at <http://www.tricare.mil/mybenefit/home/overview/enrollment> to fill out and mail to a TRICARE regional office. Beneficiaries can also visit a TRICARE Service Center to enroll and get assistance with other healthcare needs. ⚓

–TRICARE Press Release, 13 November 2007.

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## Truman, Arctic Assist Stranded Sailors

USS *Harry S. Truman* (CVN-75) and fast combat support ship USNS *Arctic* (T-AOE 8) rescued seven mariners adrift in a raft 23 December in the central Persian Gulf.

While conducting a replenishment-at-sea with *Truman*, *Arctic* received a bridge-to-bridge radio call from the British-flagged cargo vessel MV *British Courage*.

*Courage* was requesting assistance rescuing the stranded mariners, who were floating approximately 3 miles from *Truman*.

The ships performed an emergency break away; *Arctic* dispatched two MH-60S helicopters to the scene, and put one rescue swimmer in the water who recovered the four Pakistanis and three Indian mariners.

The helicopter crews brought the mariners to *Truman* for medical treatment, food, and water. All were transferred back to the United Arab Emirates.

The mariners had been transporting cargo from Dubai when their dhow sailed into rough seas and broke its keel. When the vessel started taking on too much water to remain afloat, the mariners abandoned ship into a life raft where they remained for 2 days before the rescue.

Coalition forces conduct Maritime Security Operations under international maritime conventions to ensure security and safety in international waters so that all commercial shipping can operate freely while transiting the region. ⚓

–USS Harry S. Truman Public Affairs.



HM2 Homer Tabeta talks to shipwreck survivors aboard USS *Harry S. Truman* (CVN-75) after they were rescued at sea. Photo by MC Matthew Bookwalter, USN

## The Spec on Specs

What do you do when your glasses break and you're heading out to Iraq tomorrow? Why, go to the optometrist's office at Camp Arifjan, Kuwait, of course.

It's a full-service shop crammed into three little rooms at the Troop Medical Clinic annex of the Expeditionary Medical Facility. "Vision ready is mission ready," said optometrist, CDR Karen Kato, who heads the only military eye care provider in Kuwait. "We provide eye care services to coalition forces. Not only for eyeglasses," she said, "but for complete eye care."

Kato's patients include service members from Great Britain, Australia, and South Korea among others, as well as U.S. forces. She sees patients from Camps Virginia and Buehring and every other location where troops are stationed in Kuwait and even as far away as Qatar and Djibouti.

All receive the benefits of a full range of care. "We do routine eye exams to check for any visual deficiencies or ocular pathology," said Kato. "About 25 percent of our services are for urgent-type care—traumatic injuries—that type of thing."

The facility is a cost saver for the Department of Defense. Patients who need eye care would otherwise have to be referred to local civilian doctors.

Of course, exams for glasses account for a lot of her work. The clinic provides the old standard military eyeglasses—jokingly referred to by some as "BCGs," or "birth control glasses" for their plain brown, heavy frames—but the inventory now has more popular wire-frame glasses.

If the prescription is in the stock inventory, a patient simply waits while the technician cuts the lenses and he or she can walk away with a new pair of glasses. The wait time is usually 15 minutes or less.

HM2 Michael Tuck Jr., thinks this is comparable to anything found in the civilian world and is first-rate. Tuck had his glasses in hand before he left the area right after he finished his exam. "This service is second to none," he said. "When they make glasses, they have a quick turnaround, and that's great service."

Kato pointed out that the clinic also makes inserts for protective eyewear. The commands buy soldiers, sailors, airmen ballistic eyewear," Kato said. "What a lot of soldiers don't know is that we can make their inserts for that eyewear."

Anyone who needs corrective lenses can get inserts in their prescription for all their protective gear, including gas masks. If you're a pilot or driver who needs sunglasses,

they have a tinting process for them too.

One of their newest acquisitions is a computerized machine that grinds multi-focal lenses. If you wear bifocals, it can take as little as 30 to 45 minutes to produce a pair. HM3 Jojo Manansala does just that and more. He's the guy who makes, fits, fixes, and tunes up glasses. It's his attention to detail that produces the high quality products for which the clinic is known. Seemingly little things, such as the distance between pupils or the height of the line for bifocals, are of critical importance for a pair of glasses to fit properly.

If the prescription isn't in stock, they have a machine that can grind and polish a lens from scratch. Most often, this machine is used to make bifocals because it's difficult to stock all the many combinations of prescriptions.

The clinic sees around 10-12 scheduled patients a day, but walk-ins can sometimes double that number. Kato estimates they see between 350-400 patients a month. That's a lot for a 3-person operation.

They work 6 days a week, however, and sometimes on Sundays. "I'd say the doc gets called in 50 percent of the time on her day off," he said. "We've made plenty of glasses after hours."

Service is their biggest goal, Cole said. "We give 100 percent. Our biggest goal is you get your glasses 5 minutes after you've been seen. We always say we're a little better than LensCrafters™," he quipped.

Kato emphasized protecting eyes. "The military issues ballistic eyewear. If you go up north [to Iraq] especially, wear it," she said. "Not only does it offer you ballistic protection, but also ultraviolet protection. UV rays from the sun can cause long-term damage to your eyes. It's like sunscreen for your eyes," she said. "Wear your protective eyewear. I can't say that enough."

Service members should heed her advice. Otherwise, they'll be back to the clinic sooner than they expect.✍

—Story by SGT1 Paul Tuttle, 1st Sustainment Command (Theater) Public Affairs Office.



**CDR Karen Kato examines HM2 Michael Tuck Jr., for glasses.**  
Photo by SGT1 Paul Tuttle, 1st Sustainment Command (Theater) Public Affairs Office

## Ronald Reagan and HS-4 Medevac 14-Year-Old Girl From Cruise Ship

Sailors from USS *Ronald Reagan* (CVN-76), and the pilots and aircrew of Helicopter Anti-Submarine Squadron Four (HS-4) rescued a teenage girl 15 December who suffered a ruptured appendix while aboard a cruise ship in the Pacific Ocean.

The girl, a 14 year-old from Albion IL, had been experiencing abdominal pains while aboard *Dawn Princess*. The Bermuda-flagged vessel was located off the coast of southern Baja California, Mexico, and was approximately 550 miles away from *Reagan* when they issued the distress call late.

“It’s a great example of the type of things we are called upon to do, and it’s neat we were able to execute it as well as we did,” said CAPT Terry B. Kraft, *Reagan*’s commanding officer.

“I was most impressed with the teamwork on board the ship. Everybody rallied together,” added Kraft. “It was a great coordinated effort between our helicopter squadron, HS-4, our medical folks, and the sailors here on the ship that enabled us to head down there very quickly. I’m also very proud of our ship’s surgeon, who completed a successful operation.”

*Reagan* responded to the call for help because it was the closest vessel with a hospital and the ability to transport and stabilize the patient.

Two HH-60H helicopters launched at 0500 to transport the patient from the Princess cruise liner for medical treatment. Because the cruise ship was unable to provide a

landing area for the helicopter, a basket was lowered in order to raise the patient into the helicopter for transport.

“The patient was stable upon arrival. However, with a presumptive diagnosis of a ruptured appendix, she was taken straight in to the operating room,” said CDR Theron Toole, senior medical officer.

CDR George Linville, MC, performed the emergency appendectomy.

Toole said that most cruise ships don’t have surgical or advanced medical capabilities and are limited to minor emergencies and some trauma situations.

“This crew is amazing. They always find a way to turn to, especially when this kind of assistance is needed, for civilians. As you saw with the San Diego wildfires, or a quick search-and-rescue operation like this, they always answer the call,” said Kraft. ⚓

—Story from USS *Ronald Reagan* (CVN-76) Public Affairs.



Laura Montero, 14, rests comfortably in the medical ward following an emergency appendectomy performed by the ship’s surgeon. Laura’s mother, Trudy Lafield (center left), was later flown to the ship and reunited with her daughter. Mother and daughter are joined by HM1 Victor Ibarra (left), ship’s nurse LCDR Laura Ledyard, and HM2 Christopher Williams. Photo by MC3 Kathleen Gorby, USN

## RDML Vinci Takes the Helm of Naval Medicine Support Command

Command of Navy Medicine Support Command (NMSC) changed hands 16 November when RDML Richard Vinci, Chief of the Dental Corps, relieved RDML Carol Turner during a change of command ceremony at Naval Air Station (NAS) Jacksonville. RADM Thomas Cullison, Deputy Surgeon General of the Navy, was the guest speaker.

RDML Turner held command over NMSC since it was established in November 2005, making RDML Vinci only the second to take control of the NMSC mission.

“NMSC is relatively new to Navy medicine,” said Vinci. “We regionalized our hospitals and now have regionalized the support functions,” he said. “And I’m just as proud as can be to be the second commander of this unit.”

NMSC may have its headquarters based at NAS Jacksonville, but the 27 activities with 4,000 plus personnel spearheading multiple missions are located in 9 countries, 12 states, and the District of Columbia.

“The five components that make up NMSC—logistics, research, training and education, public health, and IT infrastructure—are located across the entire world,” said Vinci.

After the traditional change of command ceremony, NMSC also held a retirement ceremony for Turner. Turner gave warm comments, admitting that for her it was time to move on from the Navy. She then removed her sword and presented it to her husband, symbolizing that her active-duty time was completed.

—Story by MC2 Daniel Gay, Fleet Public Affairs Center, Det. Southeast. ⚓

## Department of Defense to Provide Humanitarian Assistance to Bangladesh

In support of the United States Agency for International Development's Office of Foreign Disaster Relief, and in cooperation with the humanitarian community and Bangladesh government, U.S. Pacific Command is providing additional humanitarian assistance to reduce further loss of life and mitigate human suffering resulting from tropical cyclone Sidr that recently swept through Bangladesh causing massive flooding and infrastructure damage.

U.S. Pacific Command is providing transportation assistance, to include heavy lift helicopter support. Navy and Marine Corps helicopters from USS *Kearsarge* and USS *Tarawa* will assist with the transportation of relief supplies, equipment, and personnel.

U.S. Pacific Command sent a humanitarian assistance survey team to Bangladesh to assess support requirements with the Bangladesh military. Additionally, a Department of Defense medical team from U.S. Pacific Command that was conducting military to military medical training in Bangladesh remains to assist with relief efforts if needed. 📌

—Department of Defense Press Release, Washington, DC.

## Kearsarge Aids Tropical Cyclone Humanitarian Efforts

The amphibious assault ship USS *Kearsarge* (LHD-3), as well as elements of Amphibious Squadron 8 and the 22nd Marine Expeditionary Unit (MEU) Special Operations Capable (SOC) arrived off the coast of Bangladesh 23 November to support ongoing disaster relief operations.

At the request of the government of Bangladesh, *Kearsarge* and 22nd MEU (SOC) are coordinating with government officials, military leaders, and international aid organizations to determine how best to focus the added capabilities of the U.S. naval forces against relief efforts.

"The suffering caused by this storm is devastating," said RADM Carol M. Pottenger, Commander Task Force 76, embarked aboard *Kearsarge*. "We are here to bring help and hope to those in need and aid the people of Bangladesh during this difficult time."

Tropical cyclone Sidr slammed into the Bangladesh coast 15 November, with winds in excess of 156 miles per hour, killing thousands and leaving several hundred thousand homeless.

"The government of Bangladesh and various international aid organizations have a robust capability already in place and we will support their efforts as requested," said Pottenger. "Our forces are highly flexible and poised to help however we can."

The Norfolk-based ship's embarked helicopters and landing craft air cushion can deliver food, medicine, and thousands of gallons of fresh water ashore, helping to save lives, lessen suffering, and aid in preventing the onset of tropical cyclone-related medical issues.

"We provide a unique mix of capabilities including airlift, logistics support, and the ability to support the humanitarian relief efforts already in place," said COL Doug Stilwell, commanding officer of the 22nd MEU (SOC). "Our goal is to assist the Bangladesh government, Bangladesh military and non-governmental organizations in reducing further loss of life."

*Kearsarge* was directed to make best speed toward Bangladesh from the Arabian Sea when it became apparent that the storm was going to make landfall. 📌

—USS *Kearsarge* Public Affairs.



A corpsman with 22nd Marine Expeditionary Unit (Special Operations Capable) gives a stuffed animal to a patient in Sarankhola, Bangladesh. The amphibious assault ship USS *Kearsarge* (LHD-3) and embarked 22nd MEU (SOC) are supporting ongoing relief efforts in response to tropical cyclone Sidr. December 2007. Photo by MC3 William S. Parker, USN



LCDRs Trey Hollis (left), chief surgeon of the 22nd Marine Expeditionary Unit (Special Operations Capable) command element, and Lou C. Cimorelli, the ward officer of USS *Kearsarge* (LHD-3), provide medical aid to a child in South Khali, Bangladesh. Photo by CPL Peter R. Miller, USMC

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## Key Leaders Tour Obock Project Sites

Distinguished visitors toured several project sites in Obock to get a first-hand glimpse of Combined Joint Task Force-Horn (CJTF-HOA) of Africa's operations during a key leadership engagement in November.

High ranking officials from CJTF-HOA, the U.S. Embassy, Djiboutian government, and other agencies first met with the Obock Commissar, Obock region head government official to discuss his ideas and vision for Obock before heading out to tour the area, where the leaders visited a pier renovation project.

"The pier of Obock is one of the projects the U.S. government is working on with Djibouti so that it can be used by the Djiboutian military to better patrol the waters off the coast," said U.S. Ambassador to Djibouti, W. Stuart Symington IV.

"Obock is strategically located across from the city of Djibouti on the Gulf of Tadjoura," said RADM James M. Hart, CJTF-HOA commander. "(The pier) will also have a fishing capability as well, so it'll be commercial and naval. We'll have patrol boats from the Djiboutian navy that'll operate out into the Gulf of Aden."

"The people from the (Djiboutian) navy are really happy with this new pier that is coming next March. The chief of the navy was there, and he was very happy to see that his patrol boats would be able to be stationed there," said French naval officer, CDR Alban Lapointe, CJTF-HOA director of plans, who served as one of the primary translators for the engagement.

Following the visit to the pier, the group visited a local hospital which CJTF-HOA has been working with for several years. "We've been helping (the hospital) since about 2003 and we've got a new operating room, new radiology and pharmacy as examples of things we've done here," said RADM Hart.



Dr. Leonardo Cangronis speaks to RADM James Hart, CJTF-HOA commander, and other dignitaries during a visit to a medical clinic. Photo by Photo/Senior Airman Jamie M. Train, USAF

Following the hospital engagement, guests convoyed over to an Obock primary school where they were greeted by dozens of children, singing and dancing as they entered the compound.

The last visit of the day was to the Obock military base where the Guam National

Guard is conducting military-to-military training with the Djiboutians. Visitors to the site were able to watch the Djiboutians practice some of the defensive maneuvers that are part of their 10-week counter-terrorism training curriculum.

"I think this engagement falls into the strategic communications piece of what we do: Get our message out, show people what we're doing here, promote stability, and better governance in the Horn of Africa," said Hart.

Also in attendance for the key leadership engagement were the French ambassador and commander of French forces in Djibouti, as well as representatives from United Nations Development Programme, The Office of United Nations High Commissioner for Refugees, and the United States Agency for International Development. ✍

—Story by SGT Michelle Halpin, USA, CJTF-HOA Public Affairs, Camp Lemonier, Djibouti.

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## Djiboutians Graduate from CJTF-HOA

Djiboutian soldiers graduated from anti-terrorism and counter-terrorism military to military training, taught by Guam National Guard Soldiers currently stationed at Combined Joint Task Force-Horn of Africa, 18 December.

The Delta Company 1/294th Infantry Light Soldiers, taught the 65 Djiboutian soldiers from the Regiment Inter-Army Obock, who provide security forces for the town of Obock.

The training, which consists of varied topics like traffic control points, convoy operations, and close quarter combat, called for some long days of training.

The graduation ceremony ended with a traditional celebratory dance performed by all of the Djiboutian graduates. ✍

—Story by HM2 Regina L. Brown, USN, CJTF-HOA Public Affairs.



Soldiers from the Regiment Inter-Army Obock perform a celebratory dance after graduating from over 6 weeks of combat skills training in Obock, Djibouti. Photo by MC2 Regina L. Brown, USN

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## Cherry Point Sailor Wins Lewis L. Seaman Junior Enlisted Award

HM1 Tina Close received the Lewis L. Seaman Junior Enlisted Award for outstanding operational support during a ceremony in Salt Lake City, UT, on 14 November.

The award was established in 1998 to recognize an enlisted medical healthcare professional who has made a significant impact in the areas of patient care, clinical support or healthcare management and to their service medical mission.

HM1 Close volunteered for the Army Individual Augmentee program in early 2006 and was assigned to Kabul, Afghanistan, from March 2006 to May 2007.

While in theater, Close and her team of 24 Air Force and Army medics and Navy corpsmen were involved in a multitude of convoys and medical missions. She said it was not uncommon for the team to assist and evaluate up to 4,000 patients in a 2-3-day period for anything ranging from baby formula preparation to much more serious and complex ailments.

HMC Steven Olson, the Cherry Point Naval Health Clinic command master chief, submitted Close for the award. "Close was still in Afghanistan at the time, and I felt she really fit the categories for the award," said Olson. "She demonstrated exceptional leadership capabilities in her billet, taking charge of several enlisted medical personnel from other services while she was deployed." Olson also said Close's professionalism was one of the main reasons she was selected for deployment in the first place.

In addition to her normal duties, Close is the Cherry Point Naval Health Clinic command career counselor. "She is a strong leader and always displays a positive attitude," Olson said.

After submission, Close was selected as the Navy medicine candidate for the Department of Defense-wide competition, before being selected for the award by the Association of Military Surgeons of the United States. "It was definitely an honor to receive the award from the Navy Surgeon General," said Close. ⚓

—Story by LCPL Doug Payne, MCAS Cherry Point, NC.



(Left to Right) CPO Laurie Varner, LPO of materials management with the Cherry Point Naval Health Clinic, FORCM(FMF) Laura Martinez, HM1 Tina Close, and VADM Adam Robinson, Jr. Photo by LCPL Doug Payne, MCAS Cherry Point, NC

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### In Memoriam

CDR Michael Ray Ball, Sr., MSC, USNR (Ret.) died 7 September 2007 in Pensacola, FL. He was 59. Born in Bogalusa, LA, on 1 June 1948, "Mike" as he was affectionately known by his legion of friends and shipmates, joined the Navy's AVROC program while studying Zoology at Southeastern Louisiana College in Hammond in 1969 and eventually earned a commission in the Medical Service Corps as an industrial hygiene officer. During Operation Desert Storm, Mike was recalled to EPMU-7, then located in Naples Italy, where he traveled the Mediterranean area aboard Navy combatants. He retired from the Naval Reserve Force in December 2001.

Concurrent to his career in the Naval Reserves, Mike served primarily as an industrial hygienist but because of his sterling leadership qualities, he was assigned as the head of Naval Hospital Pensacola's Industrial Hygiene Department, and later as Director and Deputy Director of Branch Clinics 1995. He was an adjunct professor in the Biology Department at Pensacola Junior College.

Mike was nominated for the prestigious Navy Environmental Health Center's Captain Earnest Brown Award for his outstanding support to the Navy's occupational health program. He was also instrumental in the early stages of industrial hygiene exposure data tracking and automation.

Mike's second career and his life's passion was the Boy Scouts of America, where he served in a variety of leadership positions up to and including District Commissioner for the Pensacola area. He earned the rank of Eagle Scout with five Palms beyond Eagle, and was awarded the coveted Silver Beaver for outstanding service as an adult scouter. He was a life member of the National Rifle Association, and a gun safety instructor with the Florida Fish and Wildlife Commission. He loved sports including tennis and racquetball and in verification of his "sailor" roots, learned to be a charter boat captain.

Very much a family man, Mike was extremely proud of his three children and their many accomplishments. He is survived by his wife of 37 years Ann whom he always referred to as his best friend, and his children Michelle Renee Ball Shimpeno, Michael Ray Ball, Jr., Rebecca Ann Ball, son-in-law Kipp Matthew Shimpeno, and grandchildren Emily Nicole Shimpeno and Jason Tyler Shimpeno.

Mike will be sorely missed by the countless members of the Navy family with whom he served. ⚓



Camp Lemonier, Djibouti. ADM William J. Fallon, commander, U.S. Central Command, gives a quick hello to HM3 Natalie Nagye, who works in the Emergency Medical Facility at Camp Lemonier. Fallon was in the area to meet with Combined Joint Task Force-Horn of Africa leadership and discuss ongoing operations, along with extending holiday greetings to service members in camp. December 2007. Photo by MC2 Class Regina L. Brown



Atlantic Ocean. HM2 Antoinette Peterson takes a swab sample from Aviation Machinist's Mate 3rd Class Roger Cunningham to submit for a bone marrow drive aboard the amphibious assault ship USS *Nassau* (LHA-4). December 2007. Photo by MC3 Coleman Thompson, USN



Doblarchar, Bangladesh. An 11-year-old boy is treated by LCDR Lu Le, a translator, and other members of a U.S. Navy Fleet Surgical Team from the amphibious assault ship USS *Tarawa* (LHA-1). Photo by MC3 Daniel A. Barker, USN



Fallujah, Iraq. HM3 Samuel Goodwin, a field corpsman with Regimental Combat Team 6, gives medical attention to a Fallujah citizen who suffered minor wounds in a car wreck. December 2007. Photo by PFC Brian D. Jones, USMC



Yokohama, Japan. HMC Annette Wright, a member of the Commander, Fleet Activities Yokosuka Multicultural Committee, serves a hot meal at the Sanagi-tachi Homeless Shelter in Yokohama. The Multicultural Committee regularly donates to the facility, which provides meals and temporary shelter to Yokohama's homeless. December 2007. Photo by MCSN Gabriel S. Weber, USN



Kampong Cham, Kingdom of Cambodia. HM3 Kristin M. McBeath, stationed aboard the amphibious assault ship USS Essex (LHD-2), holds a young girl, while her mother is examined by a medical officer during a Medical and Dental Civic Action Project with Royal Cambodian Armed Forces and non-governmental organizations (NGOs). Photo by MC3 Christian Lemus, USN



HM3 David R. Withrow separates cans of food into different categories at the Onslow County Christmas Cheer headquarters, Jacksonville, NC. Sixty-five sailors from 2nd Medical Battalion, 2nd Marine Logistics Group, volunteered organizing and sorting donated toys and food items that were given out to Onslow County families. Withrow is assigned to Alpha Surgical Company, 2nd Medical Bn., 2nd MLG. December 2007. Photo by PFC B.A. Curtis, USMC



Djibouti. HM1 Ronie Thompson presents a gift to a local resident during a toy distribution project. December 2007. Photo by MC1 Michael R. McCormick, USN



HM3 Nicholas Rusk interacts with a student while volunteering at the Tarawa Terrace II Elementary School at Camp Lejeune, NC. The Marines and sailors of Combat Logistics Battalion 26 volunteer at the school by helping students participate in different educational activities throughout each month of the year. Rusk is assigned to Medical Detachment, CLB-26, 2nd Marine Logistics Group. December 2007. Photo by PFC B.A. Curtis, USMC

## Free Resources for Deployed Service Members and their Family Members

- Free computers for spouses or parents of deployed soldier in ranks E1 - E5.  
<http://www.operationhomelink.org/>
- Free magazines for deploying service members.  
[https://store.primediamags.com/soldier2/service\\_member\\_pg.html](https://store.primediamags.com/soldier2/service_member_pg.html)
- Free mail/gifts sent to children of deployed soldiers.  
<http://www.prweb.com/releases/2004/2/prweb106818.htm>
- Free phone cards  
<https://www.operationuplink.org/>
- Sign up to sponsor a Sailor/Marine with care packages  
<http://anysailor.com/> and <http://anymarine.com>
- Free cookies  
<http://www.treatthetroops.org/>
- Free care packages  
<http://bluestarmoms.org/care.html>
- Virtual Care boxes for troops  
<http://66.241.249.83/>
- Free books, DVD's, CD's.  
<http://www.booksforsoldiers.com/forum/index.php>
- Free care packages  
<http://www.militarymoms.net/sot.html>
- Free care packages  
<http://operationmilitarypride.org/smsignup.html>
- Sign up to receive care packages  
[http://www.soldiersangels.org/heroes/submit\\_a\\_soldier.php](http://www.soldiersangels.org/heroes/submit_a_soldier.php)
- Free gifts and care packages  
<https://www.treatsfortroops.com/registration/index.php>
- Free shipping materials for mailing to troops  
[http://www.defenselink.mil/news/Nov2004/n11232004\\_2004112312.html](http://www.defenselink.mil/news/Nov2004/n11232004_2004112312.html)

*If you would like to be on the electronic mailing list and receive the magazine in PDF format, please contact Janice Marie Hores, Managing Editor, at [Janice.Hores@med.navy.mil](mailto:Janice.Hores@med.navy.mil) or [19native47@verizon.net](mailto:19native47@verizon.net)*

## The Society for the History of Navy Medicine

### Vision Statement:

The Society for the History of Navy Medicine is an international association of people interested in the history of all aspects of medicine as it relates to the maritime environment.



### Mission Statement:

The mission of the Society is to promote the study, research, and publication of all aspects of maritime medicine.

The Society will be a means of “mutual support” and communication for people of all countries—civilian, military, academic, independent scholar, medical practitioner—who are interested in the topic.

### Joining the Society:

Anyone wishing to join the Society should e-mail CAPT Thomas Snyder, MC, USNR (Ret.) at [thomaslsnyder@gmail.com](mailto:thomaslsnyder@gmail.com). In your message please include your name, rank (if military), and list any specific interest/specialty you might have in Navy medical history (e.g., Civil War medicine, Navy nursing, hospital ships, hygiene, etc.)

The Hospital Corps Monthly newsletter is now available electronically. To have your personal copy delivered to your mailbox please contact:

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# Preventing Chaos Preparing for an Influenza Pandemic

CAPT Jesse Monestersky, MC, USN  
 CAPT James LaMar, MC, USN  
 CAPT Larry Williams, DC, USN  
 Mark Lesko

At the 2007 TriCare Conference the Navy Surgeon General (SG) addressed the need for Navy medical treatment facilities (MTFs) to “plan for chaos” referencing the potential effect on society of an influenza pandemic. Webster’s Revised Unabridged Dictionary defines chaos as “a state of extreme confusion and disorder.” The SGs intent is to prevent or lessen the effects of an influenza pandemic by ensuring sufficient planning is done by Navy medical commands and is well coordinated with federal, state, and local government authorities. Certainly, chaos will ensue if public health procedures are not planned and implemented in a timely manner, or adhered to by Navy and local authorities, as well as the general public. In response to that challenge, Naval Health Clinic, Great Lakes (NHCGL) prepared an annex to their pandemic influenza instruction.

### National and Navy Goals

The federal government’s intent is to minimize the impact on our nation’s welfare by defending the homeland, sustaining the health and safety of the populace, protecting essential infrastructure and supporting essential government functions. Navy medicine’s goals are to operate at maximum capability during an influenza pandemic and halt or slow the spread of disease

among active duty members, their families, patients, staff, and local community. We at the Great Lakes military reservation added the following to the overall goals of Navy medicine: prevent illness, save as many lives as possible, minimize suffering, ensure security, provide nourishment (food and water) and shelter for these sequestered or detained, facilitate communication, meet hygienic needs, and to be able to conduct any mission given to us by maintaining a maximum level of operational readiness. When planning for a pandemic, some find that it helps to divide a pandemic in different phases or stages and plan specific activities for each of these periods. Our recommendation is to use the most up-to-date published phases to structure interventions as this is the structure that is used in the joint military environment to coordinate operations. The World Health Organization and Federal Government have sequenced a pandemic event and the Department of Defense has set some centric planning goals.

### Assumptions

It is next to impossible to predict the effects an influenza pandemic will have in today’s environment. The effect that the 1918 “Spanish flu” pandemic had upon the world and United States may help give perspective. It killed an esti-

| Seasonal Flu  | Pandemic Flu  |
|---|---|
| Caused by a flu virus similar to those already affecting people | Caused by a new flu virus that people have not been exposed to before |
| Not life threatening for most healthy adults                    | Everyone at greater risk for serious complications                    |
| Modest impact on society  | Possible severe impact on society                                     |
| Vaccines available  | Vaccines probably not available at first                              |

Table 1. Differences between Seasonal and Pandemic Flu

mated 40-100 million people of 1.8 billion total population worldwide; a case-fatality rate (CFR) of 1-2.5 percent. In the U.S., 800,000 to 1 million died, a CFR of 0.75-1.00 percent. However, planning requires certain assumptions be made and the SG Navy Surgeon General released a list of 17 elements in his memo, "Navy Medicine Planning and Response for Pandemic Influenza," to the Navy medicine regions.

A summary of those 17 assumptions include:• An influenza epidemic will occur in the future, and the specific strain and timing cannot be predicted

- Regions will experience epidemic waves lasting 6 to 10 weeks with the worst taking place in the autumn or winter season
- All age-groups will be effected
- Focal epidemics in workforces that operate critical infrastructures (public utilities, communications, transportation, command, and control leadership) have the potential to cause disruption of services
- Standards of care may need to be altered, triage will be necessary and shortages of healthcare workers at our MTFs will occur
- Shortages of food, power, medical supplies will occur
- Social distancing, protective sequestration, voluntary and mandatory isolation, quarantine, use of personal protective equipment (masks and gloves) and cough, sneeze, and hygiene will be the best methods to reduce transmission of virus
- Public health authorities will close schools, ban public gatherings and recommend or enact other voluntary/mandatory measures, "snow-days" will be implemented for non-essential workers
- Medical intervention (pharmaceuticals-oseltamivir) may reduce morbidity and mortality
  - Supplies of oseltamivir will not be sufficient to treat all needs
  - Antibiotics can reduce mortality from secondary bacterial complications
- An effective vaccination will not be available to treat large population until months after the pandemic begins
- Military treatment facility commanding officers and region commanders may be tasked to conduct foreign and domestic civilian assistance missions

### Preventing "Chaos"

The emergence of the avian influenza H5N1 strain provided momentum to the drive to prepare for the next influenza pandemic; in fact, it may evolve into the etiologic agent responsible for the next pandemic. If and when the next pandemic arrives, there will be enormous but not insurmountable obstacles and challenges. International public health cooperation and surveillance has never been better, and there is unparalleled knowledge of infectious disease etiology (including virology, bacteriology), pharmaceuticals, vaccines, pathophysiology and principles of epidemiology. Not all pandemic influenza events develop into a worst-case scenario (e.g., Swine Flu, 1976), and our responses must be consistent with the pandemic severity and implemented in a phased approach. Triggers for initiation of responses will be provided by federal and local public health and emergency management officials

**Table 2: Pandemic Flu Planning Phases**

World Health Organization (WHO): Categorized by the ease of virus transmission in animals and humans, as well as the frequency of occurrence in both:

- Phase 1: Low Risk of Human Cases
- Phase 2: Higher Risk of Human Cases
- Phase 3: No or very limited human-to-human transmission
- Phase 4: Evidence of increased human-to-human transmission
- Phase 5: Evidence of significant human-to-human transmission
- Phase 6: Efficient and sustained human-to-human transmission

U.S. Government Stages: Characterized the stages of a pandemic in terms of the immediate and specific threat a virus poses to the American population.

- Stage 1: Suspected Outbreak Overseas
- Stage 2: Confirmed Outbreak Overseas
- Stage 3: Spread in Multiple Regions
- Stage 4: First case(s) in North America
- Stage 5: Spread in United States
- Stage 6: Recovery

United States Northern Command (USNORTHCOM) Phases. Combines the approaches taken by WHO and U.S. Government and integrates the additional consideration of operational requirements.

- Phase I: Plan and Monitor
- Phase II: Prepare
- Phase III: Manage the pandemic by shaping and/or mitigating
- Phase IV: Transition

who will categorize the pandemic influenza severity level and direct the appropriate protective measures.

NHCG's internal, worst-case scenario tripwire consists of the following occurrences: Pandemic disease is present, insufficient healthcare personnel exist, the local Navy MTF is overwhelmed by ill patients and there is a lack of clinic space, equipment, and medications. We recognize that active duty military personnel must show up to work, and force health protection, also known as personal protective measures must be strictly adhered to so that we do not become ill and are able to continue our mission. Military members must also meet the promise to render assistance to communities when called upon by our leaders.

Steps must be taken now to prepare for a pandemic flu outbreak. Partnerships must be forged and maintained. At the heart of the international plan is the aim to develop global, national, and locally relevant programs to enhance capacity to react successfully (particularly at the local level), and to problem solve when things seem to be going wrong and infrastructure support appears to be collapsing. The goal of such planning is to maintain security and essential services while preventing chaos, and to limit the mortality and morbidity of such an occurrence. Planning is being refined at the national level to assist commander's in best employing their staff and resources as a pandemic evolves.

The 1918-19 Spanish Flu pandemic demonstrated that society can survive. SARS (Severe Acute Respiratory Syndrome) was successfully contained in Toronto Canada in 2003 and the outbreak lasted only 10 days. Periodic droughts and famines have been experienced and remedies found. Preplanning will benefit us whether the next serious event is pandemic in-

**Table 3. Phases, Events and Commander’s Decisions recommended by NORTHCOM**

| <b>PHASES / EVENTS</b>              | <b>I - Plan</b>   | <b>II - Prepare</b>  | <b>IIIA - Shape</b>  | <b>IIIB - Mitigate</b>   | <b>IV - Transition</b>   |
|-------------------------------------|---|--|--|--|--|
| <b><i>Escalating Events</i></b>     | <ul style="list-style-type: none"> <li>• Appearance of H5N1 in US bird population</li> <li>• 1st Reported human infection</li> <li>• 1st report of HTH transmission (global)</li> </ul> | <ul style="list-style-type: none"> <li>• Indication of sustained efficient HTH transmission</li> <li>• Presidential direction</li> </ul>   | <ul style="list-style-type: none"> <li>• Regional or multi-regional influenza outbreaks are occurring in multiple countries, including the US</li> </ul>   | <ul style="list-style-type: none"> <li>• Widespread infection causes; mass casualties</li> <li>• civil unrest</li> <li>• Economic failure</li> <li>• Medical culmination</li> </ul>                              | <ul style="list-style-type: none"> <li>• Foreign Nations request HA/DR</li> <li>• Political instability in neighboring counties</li> </ul> |
| <b><i>De-escalating Events</i></b>  |   | <ul style="list-style-type: none"> <li>• No reported infections in US animal or human populations within a designated period of time</li> </ul>  | <ul style="list-style-type: none"> <li>• Pandemic wave significantly decreases</li> </ul>  | <ul style="list-style-type: none"> <li>• Outbreak contained</li> </ul>   | <ul style="list-style-type: none"> <li>• Civil Authorities begin recovery</li> <li>• Completion of mission assignments</li> </ul>          |
| <b><i>Commander’s Decisions</i></b> | <ul style="list-style-type: none"> <li>• Move to phase II</li> <li>• Move to phase IIIA</li> <li>• Move to phase IIIB</li> </ul>  | <ul style="list-style-type: none"> <li>• Move to phase IIIA</li> <li>• Move to phase IIIB</li> <li>• Conduct containment operations</li> <li>• Deploy forces as required</li> <li>• Move to Phase I</li> </ul> | <ul style="list-style-type: none"> <li>• Deploy additional forces</li> <li>• Begin remediation operations</li> <li>• Reinforce essential service providers</li> <li>• Move to Phase IIIB/IV</li> </ul> | <ul style="list-style-type: none"> <li>• Deploy additional forces</li> <li>• Conduct civil disturbance operations</li> <li>• Assist civil authorities in Mortuary Affairs</li> <li>• Move to Phase IV</li> </ul> | <ul style="list-style-type: none"> <li>• Redeploy forces</li> <li>• Conduct stability / HA / DR operations</li> </ul>                      |

**Acronym Dictionary: HTH (human-to-human); HA (humanitarian assistance); DR (disaster relief)**

fluenza, large scale natural disaster, or a deliberate nuclear/biologic/chemical/explosive terrorist event. The Department of Defense with its command and control structure, tested incident command center operations and experience with war fighting, have dealt with massive upheavals successfully in the past. The historical perspective of military leadership during past epidemics, describes the commanders who succeeded in minimizing illness and death through bold and prescient action. Today public health and medical interventions will require pharmacologic and non-pharmacologic controls that include vaccines, antivirals, quarantine, isolation, cohorting, shielding, and protective sequestration.

NHCGL, in a worst-case scenario, will depend upon higher authority guidance, but will be prepared to operate independently. In the worst case, healthcare would likely be minimal, with the provision of food, water, pain control, psychosocial spiritual care (mental health, pastoral counseling), but with no possibility of advanced level care (e.g., ACLS, critical care and ventilator support). Triage and mass casualty principles would apply. Riding out the 3 months or longer of the first wave of illness, and preparing for next 2-3 waves would be expected. We divided our planning into components that we felt needed attention at our base and location. These items may be similar, not applicable, or there may be other item(s) you should add that are specific to your location.

**Key components to pandemic management:**

- Employ infection control measures (cough and sneeze etiquette, frequent hand washing, personal protective equipment, respiratory isolation, basic housekeeping functions)
- Screening cases before entry into facility

- Diagnosing by use of case-definitions and rapid-influenza tests (if available)
- Quarantining patients for up to 7-days when in doubt or until the case is declared, recognizing that patients may be asymptomatic or mildly symptomatic
- Enhanced personnel protection with –95 respirators (minimum), gloves, face-shields, and gowns used as appropriate
- Termination of elective surgeries and non-urgent care
- Maintaining a healthy provider workforce in reserve instead of exposing all at once
- Establishing multiple alternate treatment sites to spatially segregate influenza-like illness (ILI) and non-ILI cases
- Rotating personnel in shifts to minimize staff burnout
- Working around expected personnel and logistical short-falls
- Expediting credentialing waivers for personnel working in the community who might volunteer to assist us
- Utilizing retirees if available and hastening their credentialing
- Recommending the wearing of masks in public may have some merit, and minimizing unnecessary public assembly
- Establishing procedures for persons and materials entering and exiting infected areas
- Asking ill staff to stay at home or not go to work until they are no longer infectious, and asking their family members to also stay home (7-10 days)
- Addressing our two largest tenant commands at Great Lakes, Recruit Training Command (RTC) and Training Support Center (TSC):

- RTC and TSC would be closed or operations greatly curtailed, with Commander Navy Recruiting Command (CNRC) concordance, whereby recruit and student training would either be suspended or abbreviated

- Healthy recruits and students would either be sent away to gaining commands, fleet ships or to deployed areas before transport is closed or, if it is too late, they would be used to support base and community efforts

- Non-essential units/services should be stopped and those personnel (civilians) would be sent home to be with their families

- During sequestration, RTC and TSC staff and instructors must be available in sufficient numbers to provide oversight and support of those under their charge, including, provision of comfort care and just-in-time training to recognize the signs and symptoms of the disease, and simple interventions

- Alteration of RTC ships, divisions, and barracks to disperse people and adjust building ventilation

- To continue to house those remaining

Naval Station Base Issues:

- Maintain essential operations as long as possible, including, power and water utilities, food services, food sales or eliminate charging for such services

- Temporary shelters or use of empty barracks for those who are segregated due to illness, or at outsiders assisting our efforts

- Remaining military personnel may be called upon to augment National Guard and/or community relief efforts

- Excess personnel will be assigned to morgue duties (collection and disposal), and other duties as required

- Ft. Sheridan, which is a small Army base outside our perimeter, may be in lock down and secured and their staff unavailable to assist Great Lakes

- A plan in place by the recruit campus and trade schools to curtail their training pipelines to reduce the size of the population requiring support by Naval Station Great Lakes

- Naval Facilities (NAVFAC) must preplan to have their essential staff available to maintain critical base infrastructure (water, electric, waste disposal, climate control)

#### **Local Community issues:**

- Other healthcare facilities might be:

- Overwhelmed

- Made off-limits for their own bio-security or containment of admitted cases

- Unable to assist with care of our beneficiaries

- Martial law may be invoked and civil order may be lost

- Civilian and beneficiary families living in the local community may be invited to move onto the base for safety medical care due to civil disorder and/or utility disruption

- Communicating and coordinating plans, policies, and recommendations with Northern Illinois Public Health Consortium, Lake County Health Department, Illinois Department of Public Health, Wisconsin Department of Health and Family Services (southeast region), North Chicago/Veterans Administration Medical Center, private and public hospitals and regional and local emergency management groups to

share information and resources and ultimately assist our communities to the maximum extent possible

Healthcare workers have an ethical obligation to help when they are needed, and the general public assumes as much. Planning and training allow us to be well prepared to make decisions to address medical emergencies, disasters or other contingencies. Personal (and family) safety is paramount to ensure that participation in preventive measures will be maximal and that our responders will not themselves become casualties.

In closing, Naval commanders in the 1918 Spanish flu pandemic, who acted quickly and decisively to restrict freedoms of movement and keep ill and the well apart, saved a multitude of lives. The same clear thinking will be required for the next pandemic that we confront. Order or chaos, rational preplanning or being left bewildered, will be our choices. Michael Leavitt, Secretary of Health and Human Services, has said it best: “we have an opportunity to become the first generation in human history to prepare for a pandemic, let’s continue toward that goal.” 

#### **Bibliography:**

CDC: Interim Pre-Pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States—Early, Targeted, Layered Use of Non-pharmaceutical Interventions, Feb 2007. (<http://www.pandemicflu.gov/plan/community/commitigation.html>)

Defense Threat Reduction Agency: Mitigation of Threats to the Continuation of Marine Recruit Training Posed by a Category 4/5 Influenza Pandemic, 29 January 2007.

CDC Flu Surge (software to estimate the impact of an influenza pandemic on hospital surge capacity) Model (7 Nov 05): <http://www.cdc.gov/flu/flusurge.htm>

U.S. Naval Institute Proceedings: Naval Quarantine – Impervious to Epidemics of Virulent Disease, Luke, Halenkamp, Kilbane, Jul 2006.

Pandemic Influenza: Clinical & Public Health Guidelines for the Military Health System, May 200: [http://fhq.osd.mil/ai-Watchboard/pdf/PI\\_Clinical\\_Guidelines\\_May\\_2007.pdf](http://fhq.osd.mil/ai-Watchboard/pdf/PI_Clinical_Guidelines_May_2007.pdf)

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# Faces of the OR

The March-April *Navy Medicine* cover featured the art of National Naval Medical Center nurse Christine Laubach. Her portrait of surgeon CAPT Kenneth S. Kelleher, MC, USN, is one of several in her series entitled “Faces of the OR,” depicting the colleagues she works beside in NNMC’s operating rooms. Here are two more of her surgeons, each dedicated to healing the victims of war and caring for other patients who rely on their unique skills.



**LCDR Tracy Rose Bilski, MC, USN**

**A**s a trauma/critical care surgeon, LCDR Bilski has treated patients wounded in mortar attacks, victims of three mass casualty events, and survivors of two helicopter crashes. Dr. Bilski has a philosophy of treating all people the same. “You can’t treat an OIF patient any differently than a drug addict. Everyone gets treated equally and I fully believe in the cause.”



**CAPT William A. Liston, MC, USN**

**C**APT Liston loves hands-on patient care and transferring that passion to residents and students. “It is not only our responsibility to care for patients but also to pass on this gift to other generations.” He especially has an interest in treating war casualties and breast care patients. He feels his Navy career has provided him the opportunities to touch so many people and make friends that span the globe. “Live life like you’re not going to be here tomorrow,” he says.

# “Stepping Stones to Tokyo” Release



Videographer Michael May contemplates a collection of dog tags left atop Mount Suribachi by U.S. service members in tribute to the American fighting men who gave their lives on Iwo Jima. Photo by CAPT David Lane, MC, III MEF Surgeon



Deep inside a once-fortified cave, Japanese visitors have left makeshift shrines in memory of soldiers or Japanese civilians who died in the Battle of Saipan. Photo by Jan Herman

The Battle of Midway in June 1942 may have been the so-called turning point in the Pacific for having stemmed the Japanese advance during World War II, but winning the war at sea was not enough. Retaking the Japanese-held islands for the final assault on Japan was another priority. The nature of island-hopping through a far-flung and often tropical environment required a new medical strategy. Navy medicine had to overcome both the environment and the Japanese. Throughout the Pacific War, corpsmen and physicians—personnel of the Navy Medical Department—were entrusted with the health of the troops and providing aid when they were injured in combat. They went ashore in places most Americans had never heard of—Guadalcanal, New Britain, Tarawa, Eniwetok, Kwajalein, Saipan, Tinian, Peleliu, Iwo Jima, and Okinawa, to name but a few. And like the Marines they served, these non-combatants also confronted the deadliest enemy American fighting men had faced in any war. Much was expected of them. ⚔



A rusting Japanese gun points at a now peaceful Saipan jungle. Photo by Thomas Webster

The soon-to-be released 30-minute video, “Stepping Stones to Tokyo,” in the Bureau of Medicine and Surgery’s six-part series, *Navy Medicine at War*, is the fifth installment of the series. The first four are available on DVD.

You may order “Stepping Stones to Tokyo” and copies of the other releases from Visual Information Directorate, NMSC, Bethesda, MD, Tel: 301-295-5595.



Thomas Webster (left), Michael May, and guide, Jerry Facey, look seaward near “Banzai Cliff.” Having fled to this northernmost part of the island to escape the fighting, many of Saipan’s civilian refugees chose to leap to their deaths rather than surrender to the Americans. Photo by Jan Herman



On one of Iwo Jima’s black sand invasion beaches, Navy Medical Department Historian Jan Herman describes the bloody events that occurred there 62 years ago. Photo by CAPT David Lane, MC, III MEF Surgeon

## HMS Amethyst Update

HMS *Amethyst’s* Angel of Mercy,” published in the July-August 2007 edition of *Navy Medicine* told the story of LCDR James Packard, MC, USN, and his valiant mission to render medical assistance to the beleaguered crew of the British frigate *Amethyst* during the Chinese civil war. Some 58 years after Chinese communist forces targeted their ship on the Yangtze River, surviving members of HMS *Amethyst* reunited with their U.S. Navy benefactor. Although, as a foreign national, he was ineligible to receive the Naval General Service Medal with Yangtze clasp officially, the crew saw to it that Dr. Packard got one anyway. As K. Stewart Hett, one of *Amethyst’s* officers, stated: “The medal is an unofficial gesture from the veterans from HMS *Amethyst*. There is no way that we could persuade Her majesty the Queen, or the Ministry of Defence to authorise the award and register it in the *London Gazette*. But I am sure none is going to question our action nearly 60 years after the event.”

And Dr. Packard’s response:

c/o Mr. K. Hett  
5 Moor Park Road  
Northwood  
Middx HA6Y2DL

Dear Stalwart men of H.M.S. Amethyst:

Thank you so very, very much!

It was so very kind and thoughtful of you to remember me after low so many, many years.

It was not only thoughtful but the manner in which you presented it that was so original and striking! It appeared on the front page of the city newspaper. This is not just the city newspaper, it has the largest coverage of central Florida and of the University of Florida. Shortly after that article appeared in the newspaper (the Gainesville Sun) you sent full coverage which appeared in the Florida Medical Journal.

The next to arrive was the Naval Medal with ribbon and Yangtze Clasp and certificate of appreciation.

I can never thank you enough. It has been many years since I was in England. At my age it is doubtful if I will be able to travel there again. But nothing would give me greater pleasure than to shake the hand of each and every one of you. You shall always dwell in my heart. God Bless You All!

James Packard Jr., MD



# Anguishing Decisions

*In 1965, the Navy created Naval Support Activity (NSA) Danang to support the Navy and Marines operating in the northern provinces of South Vietnam (I Corps). Providing emergency and definitive medical care for Navy and Marine Corps personnel became the mission of the Naval Support Activity Station Hospital (NSAH), which soon grew to be the largest land-based medical facility in Vietnam. The advanced emergency hospital center was designed to provide specialties not usually represented in the medical battalion hospitals, such as neurosurgery, dermatology, urology, plastic surgery, ophthalmology, and ENT (ear, nose, and throat) treatment.*

*Construction of the hospital center began in July 1965, but 3 months later the Viet Cong attacked the site with satchel charges and mortars, destroying much of the compound. Despite this devastating setback, the hospital opened for business in mid-January 1966 with 120 beds. During 1966, 6,680 patients were admitted. Two years later, during the peak of American involvement in the war, the bed capacity increased to 700 with 24,273 admissions. The facility also included a dental department, preventive medicine unit, blood bank, frozen blood bank, and a detachment of the Naval Medical Research Unit-2 (NAMRU-2), then headquartered in Taipei, Taiwan.*

*CAPT Harry Dinsmore, an experienced veteran with more than 20 years in the Navy, was NSAH's Chief of Surgery from July 1966 until August 1967. Dinsmore recalls the hospital's early days.*

The staff at Danang varied between 25 and 30 people. The administrative staff consisted of 15 or 16 people plus Medical Service Corps officers and such. I can't recall how many corpsmen we had. The hospital continued to expand during the 13 months I was there. They were still in the building phase at that time, and we continued to add additional specialties as we increased the staff. Dental surgeons and plastic surgeons arrived, as did a neurosurgeon. We had a lot of head injuries in Vietnam from land mines so our neurosurgeon was kept really busy.

It went in spurts along with the battle activity. If we had an offensive like Tet or another big operation going on anywhere in I Corps, which was where we and the Marines were, a lot of casualties came in. And as it turns out, I was the main triage officer for the I Corps area for at least part of that year.

We had three major hospitals in the area: Naval Support Activity Hospital (NSAH) where I served, the hospital ship in the harbor at Danang, and Charlie Med in West Danang.

NSAH had a big helipad and a large reception area where the medical casualties arrived by chopper. A lot of the helicopter casualties came to us. "A lot" meant more than a dozen injured. We could handle a dozen or up to 20 with no particular problem because we had enough staff and three or four operating rooms. But when we got 60, 80, or 120, and the chopper pilots would tell us more



Naval Support Activity Danang

Photos from BUMED Archives

were on the way, triage was necessary. I had to decide who went to surgery first—a very unpleasant duty because triage officers had to decide who was to be allowed to die, that is, they were not savable. When we had a large number of casualties, I would go to the administrative shack which had a radio and get in touch with Charlie Med and the hospital ship, which I believe was the *Repose*.

Our hospital in Danang was really good, especially after we got the capability of a neurosurgeon. We already had orthopedists and general surgeons. We added a urologist and then plastic surgeons were assigned.

We only received sporadic casualties if no major battles were going on. We had post-operative patients to take care of, and we made rounds every day. Once the seriously injured were stable, they were air-evaced to Clark Air Force Base Hospital in the Philippines or back to the States so we didn't have many long-term casualties. We kept those who looked like they would recover long enough to get back to active duty within 2 or 3 weeks. But other than that, we had mostly short-term patients who were air-evaced out to make room for more serious ones.

When casualties were light, we got pretty bored. After all, we were living in a bunch of Quonset huts on a sand dune with nothing to do. During those slow times, we operated on cleft lips and palates, very common congenital anomalies in the Vietnamese population. Many children had these conditions and we did corrective operations on them. The word got around and children would be brought to us. When we had light days of surgery, we'd schedule four or five harelips to do in a morning. All the surgeons did this kind of operation at one time or another, and we did hundreds of them that year. Most of the severe cleft palates were supervised by the plastic surgeon and the oral surgeon.

In addition, we treated many ARVN [Army of the Republic of Vietnam] soldiers. In addition to our long Quonset huts for our own surgical casualties, the hospital was divided into Quonsets for different tasks. The internal medicine Quonsets were in a different location from the surgical units. They treated malaria, dysentery, etc. A separate hut held 25 to 30 beds for Vietnamese soldiers. Because Danang had an ARVN hospital in the city, these South Vietnamese soldiers would be transferred to that hospital as soon as we stabilized them. We also had a Quonset hut for POWs. We actually operated on many "Charlies" [Viet Cong] who were brought in with other casualties. Interpreters and Marine guards were always in that building.

I did so many surgeries that it is hard to recall specific ones. I tried to save some tremendous liver injuries, that is, those people who would have died within a half hour. And some of them died because you can't put a completely shattered liver back together. Because we had excess amounts of blood, we could work on them for a couple

of hours and try to salvage them—try to repair torn hepatic veins where blood was just pouring out. We had many of those kind of casualties and multiple amputees from land mines. Some had both legs gone, an arm gone, or maybe both arms gone. Some had been blinded—all terrible injuries.

But we had to try to do something for them. If we had many casualties, we just made some of the more serious injured comfortable and administered morphine. We couldn't let them take up operating room space when we had many others who could be salvaged. It was a lousy decision to make.

I remember one Marine colonel who showed up wanting to look in on some patients from his unit who had been injured by mortar fire. After he had been there a few hours walking around, he complained of a headache which kept getting worse and worse. Although he appeared uninjured, we took an x-ray of his head, which showed a metal fragment in his brain. He had no obvious external wound; he didn't even know he'd been hit. We found a wound inside his hairline where it wasn't obvious. One of the tough aspects of wartime surgery—and in civilian surgery, too—is finding foreign bodies. The body is three dimensions and an x-ray is two dimensions. To try and get that third dimension, you take lateral and front views to pinpoint exactly where a foreign body is. The x-ray showed the fragment in the posterior part of his brain; the neurosurgeon removed the fragment.✂



**CAPT Harry Dinsmore receives the Navy Cross and congratulations of GEN William Westmoreland, Commander, U.S. Military Assistance Command, Vietnam (COMUSMACV)**

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Dr. Dinsmore received the Navy Cross for removing a live mortar shell from a South Vietnamese soldier, becoming only one of four Navy physicians to be awarded that medal during the Vietnam War. (See "Dr. Dinsmore's Souvenir," *Navy Medicine*, November-December 1989, pp. 6-9.) He retired from the Navy in 1967 and practiced medicine in Punxsutawney, PA, until retirement in 1991. He died in 2003.

# BUILDING A SEA-BASED MEDICAL SUPPORT SYSTEM

## PART I: THE STRATEGIC ENVIRONMENT

CAPT Arthur M. Smith, MC, USNR (Ret.)

Competition between state-based conventional and nuclear forces dominated the global security environment during the 20th century. Today, the United States and its allies face a far more complex landscape of unconventional dangers, ranging from terrorism and insurgency to trafficking in illicit weapons technology and illegal migration. Many of these problems have a maritime dimension that is typically manifested in littoral areas near shipping lanes and population centers where commerce and maritime traffic are densest.

Some of these issues such as drug smuggling and piracy are not new, but they assume greater importance as state-based threats recede and globalization empowers previously disenfranchised groups. These same adverse elements, although possessing no significant capability on the high seas, are very active in littoral regions. They have sought to reduce U.S. access to areas where it was formerly active, either by denying use of local bases or simply by making it too dangerous to be in the “neighborhood.”

As such, the strategic concept of U.S. military operations is moving from a geographic environment wherein the Navy operated primarily by itself in mid-ocean waters to one in which expeditionary/amphibious war-

fare would henceforth be conducted in heavily defended littoral waters. Most likely, this action would be conducted in a joint or combined manner, from over-the-horizon geographically dispersed bases at sea independent of land-based logistic lodgments. Future expeditionary military forces emanating from such bases will no doubt be involved in a wide array of missions, ranging from disaster relief and humanitarian operations to full-fledged sustained combat at sea and ashore. Most likely, there would be those conflicts wherein the bulk of fighting would be performed by either joint or combined task forces.

To meet the challenges posed both by the prevailing security environment as well as projected future requirements, an inclusive concept for implementing joint sea-basing of operational forces has evolved. Described by proponents of the new sea-basing strategy as a “distributed war-fighting architecture,” those proponents have hoped to align it with both the anticipated future strategic environment and the likely security challenges of the 21st century. The distributed network concept entails an extensive transformation of the employment of maritime forces, utilizing fewer available afloat assets than traditionally utilized in past conflicts. Likewise, given

the breadth of anticipated operational requirements, this diminished number of maritime platforms will, by necessity, be widely dispersed geographically. It is expected, however, that these operational units will be integrated with organic and distributed sensor and communications nodes. By interconnecting all the platforms and major systems deployed by the U.S. sea services to facilitate information sharing, namely ships, submarines, aircraft, unmanned vehicles, and Marine Corps units, as well as joint and combined forces, it is hoped to afford operational commanders with a fully “networked” battle force.

### **Necessity For a Sea-Based Medical Support System**

Whether single or multiple afloat platforms are utilized in sea-based expeditionary operations, there will always be the potential for personnel acquiring sickness and experiencing injury. These conditions may be incurred on land and transferred seaward, or acquired aboard vessels at sea. As such, every expeditionary logistical plan must include the possibility of human casualties, and these realities must be factored into every operational equation.

In conjunction with these new and evolving operational requirements that emphasize joint and combined

expeditionary operations, a medical support system and its component material parts must be designed to supply speed, flexibility, and responsiveness to changing tactical and strategic requirements. Equally necessary is the corollary that every type of military logistical support mechanism, including medical services, must be adapted to the nature of the conflict being addressed, and be compatible with the operational concepts employed by the combatant commanders.

In the current context, revised and flexible mechanisms for joint medical support of operational maneuvers will be required to support the paradigm shift in casualty care. This will be especially necessary during geographically dispersed “distributed” sea-based operations in the littorals, wherein minimal medical facilities are accompanying forces going ashore.

Consequently, the advent of the integrated “Base at Sea” requires its own unique form of adaptive medical systems engineering. Within this context, configuration management of medical systems will be extremely important to ensure connectivity among systems and components for both technical support and logistics.

The implications for combat casualty management within this new concept of expeditionary operations clearly require the attention of patient care advocates within Navy medicine, notwithstanding kindred medical staffs of the allied armed services. Well conceived plans for the concurrent integration of contingency health care assets are critical. Neglect of this critical element may taint any grand operational design. As such, it is incumbent upon health care providers to actively participate in defining what is possible and set pragmatic goals for patient management within this new evolving operational architecture. Likewise, they must develop effective systems to integrate healthcare within the com-

plex “system of systems” now known as sea-based expeditionary warfare.

The first portion of this series of essays deals with the operational setting of sea-based operations. To understand the changes required in joint operational medical support doctrine, it is necessary to understand the recent evolution of U.S. global military strategy that prompted the re-direction toward utilization of bases at sea. Subsequent iterations within *Navy Medicine* will discuss the requirements for Navy contributions to medical support, and a final segment will discuss the complexities of joint interaction in sea-based expeditionary operations.

### **Transformation of U.S. Global Military Posture**

To facilitate a favorable military balance in both peace and war, the ultimate aim of the U.S. global military posture has been to create advantage in strategic reaction time, as well as in the positioning, concentration, and sustainment of its forces. Consequently, the faster a joint U.S. military force can project power over transoceanic ranges, and the greater the area over which it is able to both conduct and sustain operations, the greater its degree of strategic mobility.

**World War II.** During World War II an overall Global Expeditionary Maneuver and Movement System was designed to support the combination of operational maneuver from strategic distances, operational forcible entry maneuver from the sea, as well as global repositioning of forces, equipment, and supplies. It included both a large amphibious landing fleet and airborne forces for operational maneuver from strategic distances and forcible entry, a 5,000-ship sealift fleet, a 3,800 aerial transport fleet for global movement of forces, equipment, and supplies, as well as naval combat and logistics forces in addition to rapid base construction forces. Cumula-

tively, these enabled the formation of vast sea bases, and expeditionary base sets. Concurrently, a widely distributed network of mobile medical services, base hospitals, advanced base functional component system station hospitals, and both regional and strategic casualty evacuation systems was established.

**Cold War.** In order to counter a widely distributed and networked enemy during the Cold War’s evolution, a distributed global network of fixed bases was required. The Global Expeditionary Maneuver and Movement System was consequently transformed into a network refocused on rapid reinforcement of strong forward located garrisons, thereby diminishing the need for operational maneuver from strategic distances. Indeed, jet transport (Civil Reserve Air Fleet or CRAF) became the primary means to move personnel; and sealift (Ready Reserve Fleet or RRF) as the primary means to move heavy cargo. Prepositioned land-based equipment sets became increasingly important in reducing reinforcement timelines. With assured forward access, there was no strong demand signal for forcible entry forces, and the amphibious landing fleet and airborne forces gradually diminished in size.

**Post Cold War.** Since the conclusion of the Cold War yet another new national security era evolved challenged by the increase of asymmetric terrorist warfare. While the threat from radical Islam is global, the ranks of its forces are thin. Without an organized and compelling global ideological threat, it has been practically impossible to justify a global basing network with large numbers of foreign external bases. With far fewer forward-based forces on foreign soil in Europe and in the Pacific, remaining U.S. foreign bases are being converted into a new type of global expeditionary “coaling station” network designed to support

the rapid global concentration of U.S. expeditionary forces across trans-oceanic ranges. These include both “warm” and “cold” forward operating sites and cooperative security locations with extremely small footprints. Bases in Europe are now viewed more as “strategic trampolines” to support the rapid deployment of U.S. forces moving both east and south. This explains why all services are now emphasizing expeditionary capabilities, deployability, and joint interoperability. The transition to an expeditionary posture has also spurred a reshuffling of the land-based pre-positioned equipment sets utilized by the Army. This transition has also prompted the Army to adopt maritime pre-positioned forces as well. As the scope of this change evolves and the military transforms, the result will be fewer overseas bases and a larger push for rapidly deployable forces based in the continental United States (CONUS) as well as prepositioned afloat forces. This nation’s global military posture is thus becoming, once again, more expeditionary in character and global in its orientation. As such, medical support must once again readjust in support of these changes.

### **Current Expeditionary Focus**

Because radical Islamists do not yet possess large forces, the U.S. military footprint in threatened areas has been kept relatively small, with proposals for a global network of “micro bases” to include mobile sea bases. Future sea-based maneuver forces will therefore require the capability to exploit the sea as maneuver space even if confronted by a determined adversary. Likewise, they must be able to facilitate joint access and support joint power projection operations without reliance on land bases. The joint sea-based force will ultimately need to supply speed, flexibility, and responsiveness

to changing tactical and strategic requirements.

The concept of the new global military posture entails many facets: new combinations of immediately employable forward deployed forces such as those within expeditionary strike groups with forcible entry capabilities allied with carrier battle groups; globally available reconnaissance, strike, and command and control assets; information operations; special operations forces; and rapidly deployable sustainable forces that may come from outside a theater of operations. It also utilizes mobile sea bases to bridge the “gap” between the shrinking numbers of forward-based forces and those forward-deployed. Extended naval patrols comprising substantial maritime forces conducted on a continuous or near-continuous basis represent yet another form of distributed, mobile (sea) bases. In terms of overall demand, the mobility and logistics requirements of U.S. forces may remain relatively small as long as the radical Islamist movement does not metastasize. Nevertheless, since “actionable” intelligence may be highly perishable, U.S. forces must be positioned at these locations to act quickly.

Within this context a notional Global Fleet Station (GFS) concept has been proposed within the Navy. These distributed mobile sea bases, or GFSs, would temporarily substitute for land bases by establishing a temporary overseas presence, reinforcing threatened portions of the U.S.’s extended defensive perimeter and serving as the initial bridge to geographic areas not covered by an existing exterior basing network. They would consist of five afloat units each built around either an LSD, an LPD, or a high speed vessel (HSV) supported by either frigates, littoral combat ships, or other afloat assets depending upon combatant commander requirements, the op-

erating environment, and the specific mission. Such units might be stationed in either Guam or Singapore; Bahrain or the United Arab Emirates; as well as in Diego Garcia; Rota, Spain; and Key West, FL. Their mission would be to provide a self-sustaining home base from which to launch operations ranging from theater security cooperation to maritime interdiction and counter-piracy operations. They could also serve as a base from which to sustain and deploy riverine units and conduct missions in direct support of the Global War on Terror. They might likewise serve as logistics centers and command and control for regional expeditionary operations, as well as home base for naval construction battalions, salvage divers, explosive ordnance disposal, and medical teams. Such bases at sea might also serve as group headquarters for regional operations and perhaps also possess a medical treatment facility, although the capabilities of the latter, beyond that of first aid stations, remains unresolved. Likewise these afloat stations could potentially serve as launching pads for response to humanitarian crises, natural disasters, and counter-terrorism operations while also acting as global maritime intelligence feeders to offer maritime domain awareness to host nation partners.

### **Restraints to Operational Flexibility**

The overarching constraint of limited operational accessibility is managed first by having the ability to transport forces and then attaining access to wherever they are needed to meet a theater commander’s objectives. As noted, toward the end of the 1990s concerns evolved regarding the possibility of encountering scenarios in which U.S. freedom of action around the world might be severely restricted by having little or no access to regional bases. Such lack of local access has been attributed either to the simple

absence of such facilities in less developed regions of the world, the unwillingness of local nations to provide access because of a lack of self interest in supporting U.S. military operations, or an adversary's military ability to deny facilities to U.S. forces by either attack or by the threat of attack. In Afghanistan in 2001, for example, military operations required extensive logistical adaptation to the reality of Central Asia's very limited local infrastructure. Once again, in Iraq during 2003, the risks of taking for granted the availability of local infrastructure were highlighted by two events: the reluctance of Saudi Arabia to offer host nation support to the United States of the magnitude it had during the first Gulf War; and by Turkey's decision to

deny transit rights to U.S. Army units bound for northern Iraq.

Attention has consequently shifted toward development of systems and operational concepts that will make the transportation and employment of ground combat forces less sensitive to access constraints. ("Access insensitive" describes forces that can be operated with little or no reliance on bases or other logistics infrastructure on the ground in their immediate area). Implied, is the ability to deliver combat ready ground units directly to their area of operations independent of local permission. A forcible entry capability that requires neither ports nor air bases for its implementation is required. Also needed is the ability to support those forces for extended pe-

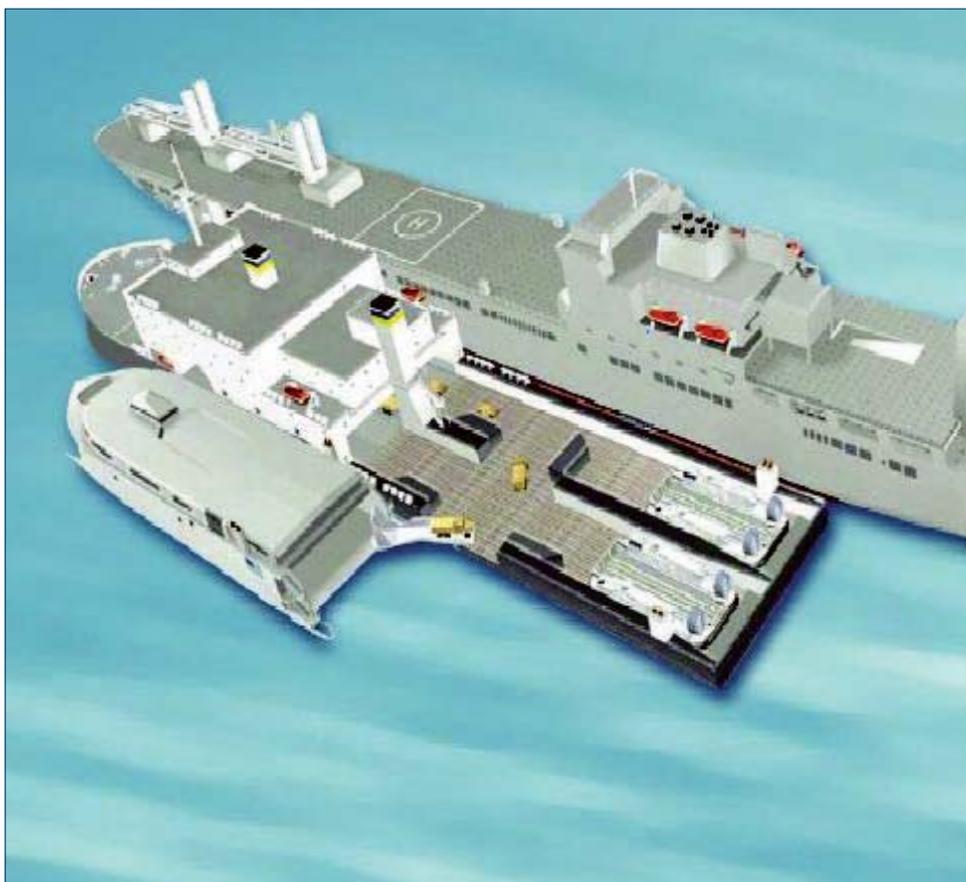
riods independent of local permission or infrastructure, implying an "access insensitive" or independent ability to deliver supplies, maintain equipment, and provide medical care. Ultimately required, as well, is the ability to withdraw ground forces from an area of operations and quickly reconstitute the force for subsequent use elsewhere in the area or in a new theater.

Reminiscent of the seaborne operations of World War II, the operational concept of "sea-basing" has thus re-emerged as an approach that might offer similar expeditionary capabilities. It would primarily take advantage of the freedom of U.S. maritime and Navy forces to operate anywhere in the world in international waters. A primary DOD effort to improve access insensitive capabilities in this regard

is a plan to field geographically distributed and integrated joint, networked systems, or sea bases. This effort would concentrate on transporting, employing, and sustaining ground forces from ships at sea and building upon the existing deployments of Expeditionary Strike Groups and Carrier Battle Groups around the world. The medical support implications warrant further discussion and analysis. ⚓

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The drawing illustrates an early U.S. Navy conceptual drawing of a sea base operating in support of ground forces. A large, medium-speed roll-on/roll-off ship (top) and an intra theater high-speed vessel (bottom) are shown alongside a notional mobile landing platform (center) with two air-cushion landing craft parked on its stern. Photo from: <http://www.cbo.gov/ftpdocs/82xx/doc8284/07-05-Seabasing.pdf>

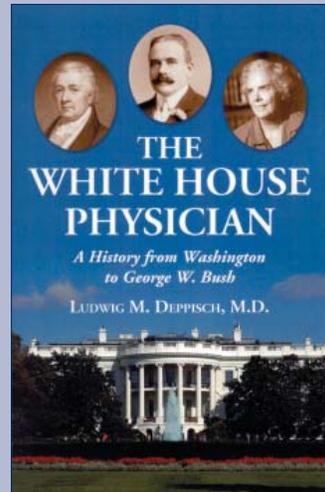
## Book Review

*The White House Physician: A History from Washington to George W. Bush* by Ludwig M. Deppisch. McFarland and Company, Jefferson, NC. 266 pages.

On 13 June 1789, the well-respected New York physician Samuel Bard was summoned to a stately house at No. 3 Cherry Street in lower Manhattan to treat an individual struck by high fever and pains in his left thigh. As it would turn out, this was not a typical house call. The patient was George Washington, and the dwelling was the executive home. Bard's visit would precipitate the 218-year history of the presidential physician. It is this topic the author excellently captures in his book *The White House Physician: A History from Washington to George W. Bush*.

Dr. Bard was chosen chiefly because of his reputation. Future attending physicians to the president were sometimes selected for their "availability" or perceived specialty. In 1823, when President James Monroe was seized with an acute illness, Navy surgeon Bailey Washington, then on duty at the nearby Washington Navy Yard, attended Monroe. Washington was to be the first of many military physicians to treat a sitting president. A decade later, Andrew Jackson called upon Navy surgeon Thomas Harris to remove a bullet embedded in his left shoulder ever since a duel in 1813. As Deppisch speculates, Surgeon Harris was chosen "presumably because a military doctor would have greater experience than a civilian doctor in treating gunshot wounds." At the time, Harris was a professor of "operative surgery" at the Philadelphia Medical Institute.

Other Navy physicians would act as full-fledged White House physicians serving the president throughout their administrations: Jonathan Foltz (James Buchanan), Presley Rixey (Theodore Roosevelt), Cary Grayson (Woodrow Wilson), Joel Boone (Warren Harding, Calvin Coolidge, and Herbert Hoover), Ross McIntire (Franklin Roosevelt), George Burkley (John F. Kennedy), William Lukash (Gerald Ford), and Eleanor Mariano (Bill Clinton). Deppisch



captures all their careers in his book; in fact, both Rixey and Boone are the subject of their own chapters—"Admiral Presley Rixey: The First Authentic White House Physician," and "Captain Joel Boone and the Institutionalization of the Office of the White House Physician."

In presenting these stories, Dr. Deppisch does a service for the Navy, and, especially,

the Navy Medical Department. He reminds the reader that Navy medicine has played an integral role in developing the present-day White House Medical Unit (WHMU) and defining the field of "executive medicine."

This book is an essential-read for any Navy medical recruiter wishing to present the many unique opportunities that have been and continue to be open to Navy physicians.

Although *The White House Physician* seems to target medical, military, and presidential historians, others will also enjoy this book, particularly the inquisitive reader who has ever wanted to know:

How physicians are assigned to the White House. Is there a typical White House physician-president relationship? Who were the colorful characters that served as White House physicians? What are some of the medical ailments presidents have suffered? What does a White House physician do after retiring? Who cares for the vice president and first families? How has the role of presidential physician evolved?

This nation has had a long fascination with its political leaders, particularly its presidents. If their health is almost always overlooked in the reconstruction of presidents' lives, in many of those biographies the White House physician is but an endnote. Happily, Ludwig Deppisch's *The White House Physician* is the perfect remedy for this unfortunate negligence.—ABS 

# Navy Medicine ca. 1958



BUMED Archives

LT Max Perlitsch, DC, USNR, performs cold weather dentistry at McMurdo Sound, Antarctica.

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