

Navy Medicine

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Conspirator or Hero

NAVY MEDICINE

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Cover: VADM Ross T. McIntire, MC, USN, served as Surgeon General of the Navy and Chief of BUMED from 1938 to 1946. As White House physician, he was also responsible for the health of President Franklin D. Roosevelt. Recent scholarship has added a new dimension to his tenure. Story on page 21. Portrait by CDR Samuel Bookatz, MSC, USNR (Ret.). Photo by HM1 Stephen Oreski, Medical Photography, Navy Medicine Support Command.

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.

SAVE A TREE

If you would like to receive your issue electronically via email in PDF format, please contact
Janice Marie Hores, Managing Editor, at
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LETTERS TO THE EDITOR

Dear Sir or Ma'am,

MC1 De La Cruz's article on malaria research could have used stronger scientific editing. The second paragraph states, "...there is still no cure for malaria," and then goes on to say, "... [but] a cure is much closer." This is a terribly incorrect statement with which to begin an otherwise valuable and interesting article.

There are many cures for malaria, and any sailor infected with any of the plasmodial species can expect to be 100 percent cured with currently available treatments. Please let no one at the offices of *Navy Medicine* or elsewhere in the naval community labor further under this gross misperception. Malaria is a 100 percent curable disease. If untreated, it can be fatal, IF UNTREATED. The take home message for those living and working in malarial areas is this: use one or more of the currently available prevention methods, seek treatment early for symptoms, and continue to support research into a safe and effective vaccine. An ounce of prevention is worth a pound of cure. Don't short change your readers with inaccurate information.

LT Michael Kinzer, Research Medical Officer
NAMRU-2, Jakarta, Indonesia

DEPARTMENT ROUNDS

NEW CLOTTING AGENT GETS DOD'S OK

Defense officials have recommended a new clotting agent as a backup to treat life-threatening bleeding. The granular substance known as "WoundStat" was tested along with Combat Gauze, QuikClot and "Hemcon" bandages, said Dr. David S. Wade, of the office of the Assistant Secretary of Defense, Health Affairs.

Studies have shown that WoundStat and Combat Gauze worked best to stop bleeding, Wade said. Based on the results, the DOD Committee on Tactical Combat Casualty Care recommended that Combat Gauze and WoundStat be used as the first and second lines of treatment respectively for bleeding that cannot be stopped with a tourniquet.

Medical personnel prefer to use gauze instead of something granular as the first line of defense against severe bleeding, Wade went on. "This preference is based on field experience that powder or granular agents do not work well in wounds where the bleeding vessel is at the bottom of a narrow wound tract," he said. "A gauze-type hemostatic agent is more effective in this setting."

In other words, applying Combat Gauze to bullet, stab, or shrapnel wounds works better because you are applying both pressure and a clotting agent to the bleeding vessel, kind of like filling a hole with putty instead of sprinkling filler over a hole, a Defense health official pointed out.

However, WoundStat may be the better option to get into the nooks and crannies of irregularly shaped wounds, such as those from roadside bomb blasts, said Devinder Bawa, chief executive officer of Bethesda, MD, based TraumaCure, Inc., the company that makes the product. It can also stop bleeding in places where tourniquets won't work, such as the femo-

ral artery in the groin area, said Bawa. "That's exactly the type of injury that these products are tested on."

WoundStat has also shown it can stop high pressure bleeding within a minute, unlike other products, which can take several minutes. "It's very effective, particularly in forming a seal and adhering to the wound," he said.

Dr. Kevin Ward, one of the researchers from Virginia Commonwealth University who invented WoundStat, pointed out another advantage of using this product. WoundStat can form a new seal over a wound without adding more of the product. That means you don't have to replace old bandages with fresh ones if a wound starts bleeding again.

WoundStat would also come in handy with wounds where you can't see where the bleeding is coming from, Ward said. "The way this works, you don't even need contact with the bleeding site; you just have to seal the opening."

TraumaCure is currently awaiting word from the services as to how much WoundStat they need. "Frankly, we're waiting to hear with terrific anticipation how we can begin to deploy WoundStat to boots-on-the-ground warfighters," Bawa said.

Decisions on fielding WoundStat are outside the purview of the Committee on Tactical Combat Casualty Care, Dr. Wade pointed out. "This body of subject matter experts does not make acquisition decisions for the services or medical departments. However, their recommendations are provided to medical logisticians for their consideration."

Representatives from the four services have not yet reached a decision as to whether they will buy WoundStat.✍

—By Jeff Schogol, *Stars and Stripes* Mideast edition, Friday, 13 June 2008. Used with permission from Stars and Stripes. © 2008 Stars and Stripes.

NATIONAL INTREPID CENTER OF EXCELLENCE BREAKS NEW GROUND

Met with warm weather and warmer smiles, the National Intrepid Center of Excellence (NICoE) monumental ground-breaking ceremony took place just inside the front gates of the National Naval Medical Center, Bethesda, MD, 5 June 2008. Once built, the center will host military service members needing treatment for traumatic brain injury (TBI) and psychological health issues.

Funding for the project—an estimated \$70 million—comes from the Intrepid Fallen Heroes Fund (IFHF). The 75,000-square-foot facility will provide intensive outpatient evaluation, advanced diagnostics, initial treatment plans, and will essentially aid the full recovery of warriors and their families. The IFHF hopes to mirror the success of the Center for the Intrepid, an advanced physical rehabilitation facility opened last year at Brooke Army Medical Center in San Antonio, TX, courtesy of IFHF funds.

Arnold Fisher, honorary chairman of Intrepid Fallen Heroes Fund, received a gracious ovation at the ground breaking as he addressed the audience on behalf of the IFHF. “We are no longer embarrassed to talk about the mental health of our wounded soldiers,” he said. “They deserve the best possible care, and this center will be the core of that effort.”

The Department of Defense (DOD), in collaboration with Veterans Affairs (VA) and other health and education organizations, assured the IFHF in an official written statement that a group of medical professionals will be established to provide world-class research, training, and educational support for the center. Fisher is also the vice chairman of the Fisher House Foundation, which builds homes at military installations and at Veterans Affairs medical centers across the United States. The first of the existing eight Fisher Houses was built at the Naval Medical Center. The foundation hopes to increase that number significantly, especially in Bethesda, officials said.

Prior to the ceremonial breaking of the dirt, Secretary of Defense Robert M. Gates, said that the center will help the United States Government uphold its end of a “contract” promise to provide service members and their families adequate care when injuries are sustained on duty. He expressed no higher priority than the acknowledgment of the contract, and recognized the NICoE’s future role in providing the latest treatments for traumatic brain injury. “As in every conflict in America’s history, many of our troops have returned bearing the scars of war—scars both seen and unseen,” Gates said. “These invisible wounds are in many ways more pernicious, more grievous, because they are not readily apparent and have not always received the attention they should.” Referred to as the “Center of Centers,” the NICoE is a prime example of ever-growing partnerships between government agencies like



Secretary of Defense Robert M. Gates, fifth from right, digs into the ground during the ground-breaking ceremony for the new Intrepid Center. Photo by Cherie Cullen

the VA and DOD. HON James Peake, Secretary of Veteran Affairs, expressed his hopes for successful future in caring for wounded warriors. “This Intrepid Center of Excellence will play an absolutely essential role in an unwavering commitment to continue that forward movement in getting it right in caring for those who have borne the battle.” The NICoE project is scheduled to be completed by November 2009 and is considered the first of many upcoming changes to the historic naval hospital. A merger with Walter Reed Army Medical Center is in the works and scheduled to open in 2011. The site is to become the Walter Reed National Military Medical Center.✍

—Military Health System News www.health.mil

NMSC VISUAL INFORMATION DIRECTORATE WINS TOP HONORS

The Navy Medicine Support Command (NMSC) Visual Information (VI) Directorate based at the National Naval Medical Center in Bethesda, MD, took first place in three of four categories in the 2006-2007 Navy VI Production Awards competition.

In all, more than half the entries Navywide that placed first or second belonged to NMSC VI, according to results released on 21 March by RDML Frank Thorp, Navy Chief of Information (CHINFO).

NMSC VI manages and executes VI and audiovisual programs, providing global support to Navy medicine. NMSC VI took first place in the Recruiting Category with their *National Disaster Medical System: Delivering Medical Care in Times of Crisis* video.

NMSC VI took both first and second place in the Internal/Public Information Category with *The Naval Ophthalmic Support and Training Activity: Providing the Sight to Flight*, the first-place winner, and *Assuring a Sustained Preparedness: A Federal, Military, and Community Partnership* video, the runner-up. Two NMSC VI productions tied for first place in

the All Other Category with *Veterans Day Tribute 2006-Some Gave All* and *Veterans Day Tribute 2007* videos.

“It’s very flattering to be recognized by your peers when you win awards like these,” said Tom Webster, NMSC VI project officer and video producer. “While our priority is to ensure our clients’ needs are met, it’s great to see that our videos are also well received by our VI colleagues throughout the Navy.” NMSC PAO Larry Coffey, a 2006 and 2007 CHINFO Merit Award judge in the print and newspaper category, said winning in three of four categories is very unusual.

“I’ve followed the CHINFO Merit Awards in both broadcast and print categories since the mid-1980s, and it’s rare to see one organization sweep any category of awards the way VI did,” Coffey said. “However, I’m a VI customer and have seen a lot of their work. I know their quality, so I’m not surprised. This speaks volumes about their people and their work.”

NMSC VI products also include graphic arts; layout, design and printing services; photography; and video teleconferencing support.

A sample of NMSC VI products can be viewed at www.vid.med.navy.mil

—Story by MC1st Class (SW) Nick De La Cruz, Navy Medicine Support Command Public Affairs, Jacksonville, FL.

THREE NHCCC CORPSMEN COMMISSIONED IN NAVY NURSE CORPS

Three former Naval Health Clinic Corpus Christi (NHCCC) corpsmen accepted commissions to ensign in the Navy Nurse Corps during a ceremony at Texas A&M University Corpus Christi (TAMUCC) Performing Arts Center.

HMC(FMF) Rhys Aaron Parker, HM1(FMF) Naval Aircrewman Joshua John Morgan, and HM1(FMF/SW) Lisa Marie Davis completed their requirements for a baccalaureate degree in less than 36 consecutive months while attending TAMUCC full-time.

Each pursued the advancement pathway through the Medical Enlisted Commissioning Program (MECP), an in-service procurement plan for qualified enlisted men and women wanting to earn a nursing degree and a commission.

Prior to selection Parker was the leading petty officer for Patient Services Division at NHCCC, Morgan was assigned to the Managed Care Department at NHCCC, and Davis worked at the Branch Dental Clinic, Ingleside.

LT Steve Brewster, MSC, a former NHCCC staff member, and currently the Logistics Officer, Medical Education and Training Campus, Fort Sam Houston, San Antonio, TX, administered the Oath of Office.



From left: HM1(FMF/SW) Lisa Marie Davis, HM1(FMF/NA) Joshua John Morgan, and HMC(FMF) Rhys Aaron Parker. Photo by Bill Love, Naval Health Clinic Corpus Christi Public Affairs

Besides graduating with top honors, summa cum laude, Parker also received the College of Nursing and Health Sciences O’Neil Award for Caring for his outstanding example as student leader and mentor, qualities that Parker says he will continue to draw on as a nurse.

Parker, Morgan, and Davis, are now scheduled to report to Naval Hospital Yokosuka, Japan, Naval Hospital Guam, and Naval Hospital Camp Pendleton respectively.

—Story by Bill W. Love, Naval Health Clinic Corpus Christi, Public Affairs.

MARY ALICE MORRO BECOMES FIRST NURSE CORPS OFFICER TO COMMAND NAVAL HOSPITAL PENSACOLA

CAPT Mary Alice Morro has become the first Navy Nurse Corps officer to take the top leadership role in the 182-year history of Naval Hospital Pensacola. CAPT Morro, who is the 72nd commanding officer, relieved CAPT Kevin Berry—who earned a third Legion of Merit award—in a 17 June change of command at the National Museum of Naval Aviation.

Guest of honor, RDML Matthew L. Nathan, head of Navy Medicine East and Naval Medical Center Portsmouth, VA—and former commander of the Pensacola hospital—praised both officers’ dedication and professionalism; and pointed to the “challenges ahead” that remain for each.



CAPT Mary Alice Morro addresses the audience. Photo by Rod Duren



RDML Matt Nathan (left) presents a Legion of Merit end-of-tour award to CAPT Kevin Berry. Photo by Rod Duren

NH Pensacola continues to be a “test bed for Navy medicine,” the admiral said. “And there is no other leader more committed ... and vocal” than CAPT Berry. “I know, because he’s in my ear

all the time suggesting ways Navy medicine can better take care of its service members and families. He has forced the rest of us to keep up.”

The admiral told a standing-room only crowd that CAPT Morro has a “tremendous pedigree” along with a strong clinical and administrative background that has taken her all across the globe. “She will hit the ground running” as the hospital’s commander.

“You’re coming to a community that embraces the military,” the Admiral told the incoming commander. “And, there is not any place in the world where this love-love relationship is any greater.”

Prior to arriving in Pensacola, CAPT Morro was executive officer of NH Lemoore, CA.

—Story by Rod Duren, Naval Hospital Pensacola Public Affairs.

MTF/EMF CHANGE OF COMMAND

CAPT Kevin D. Moore passed the reins of both the Medical Task Force Kuwait and the Expeditionary Medical Facility Kuwait to CAPT Elaine C. Wagner at a change of command on Camp Arifjan, Kuwait, 17 April.

Moore, who held the dual-post command for the last year has accomplished much during his time in Kuwait. Under his leadership, the Camp Arifjan hospital moved from tents into a fixed facility. The move was a key component of EMF Kuwait’s mission to provide combat force health sustainment. He has been tapped to command Naval Hospital Yokosuka Japan.

“He’s leaving me in a great position to continue the mission here,” Wagner said. “For me, the greatest things CAPT Moore has achieved are the inroads and connections he’s made with our Army teammates.”

Wagner, the incoming commanding officer, is no stranger to leading a healthcare organization. She has previously held the

positions of executive officer at Naval Hospital Jacksonville, FL, and as commanding officer at Naval Hospital Beaufort, SC.

Of the new commanding officer, Moore said “I think her strongest qualities are her humility and willingness to learn about her new operating environment—she really takes the time to assess the situation before acting.”

—Story by LT. Phillip Boyer, Expeditionary Medical Facility Kuwait, Public Affairs.

MSC OFFICER EARNS BRONZE STAR FOR YEAR-LONG TOUR IN AFGHANISTAN

CDR Anne Swap, MSC, received the Bronze Star in a ceremony on 30 May at Naval Hospital Pensacola, FL. CDR Swap received the award after a year-long tour as an individual augmentee to the Combined Security Transition Command in Afghanistan.

NH Pensacola CO CAPT Kevin Berry presented the award to Swap, who was the facility’s Director for Administration prior to the Afghanistan tour. She served in Afghanistan as the Senior Health Care Administration Mentor for the Afghan National Army, Command Surgeon directorate and the entire Combined Security Transition Command.

CDR Swap led a nationwide medical disaster preparedness effort for health services in Afghanistan, services that have been disrupted by 23 years of war. She is also credited with the multi-disciplinary implementation of policy and procedures for casualty and medical evacuations and medical regulating within the Afghan Army’s healthcare system. The

efforts “directly, and greatly improved” the delivery of medical care to the Afghan National Army, according to the citation.

—Story by MC1(SW) Russ Tafuri, Naval Hospital Pensacola Public Affairs.



CDR Anne Swap receives the Bronze Star from CAPT Kevin Berry. Photo by MC1(AW) Russell C. Tafuri

AFGHANISTAN GRADUATES FIRST POLICE TRAUMA ASSISTANCE PERSONNEL

The Afghan National Police (ANP) Central Training Center (CTC) graduated 24 police from the first Trauma Assistance Personnel (TAP) course taught by Navy hospital corpsmen.

Three Afghanistan corpsmen from the ANP medical embedded training team (METT) in Kabul taught the 8-week course at the Kabul CTC. The course provides the ANP with its first personnel certified in basic first aid and medical care skills. According to course instructors, the training is essential for the ANP.

“Just being able to put on a proper (wound) dressing is going to increase the probability of (saving policemen’s lives) tenfold,” said course instructor HM1 Ed W. Scheinert.

The METT sailors said they modeled the course after the combat medic course taught to Afghan National Army (ANA) soldiers, because ANP are just as likely as ANA soldiers to have contact with enemy fighters.

TAP Class 001 students learned to apply bandages and tourniquets and to correctly give intravenous injections, said Scheinert. They each successfully gave another student an IV injection. Students said they benefitted from the lectures and practical application.

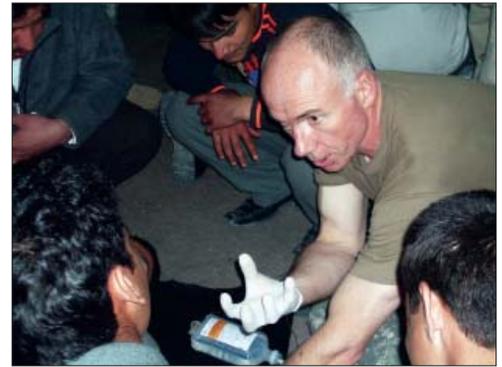
Ahmad Fawad, one of two policemen to share the honor graduate title, said he leaves with confidence that he will be able to help his fellow police in medical emergencies.

HMC Manuel A. Rodriguez, a course instructor, said he plans to recommend six graduates to become future course instructors.

The TAP students graduated at a shared ceremony with ANP in other courses at the CTC then held a follow-up ceremony in their classroom. Each TAP graduate received a certificate, a TAP patch to wear on his uniform, and a medical kit.

“That badge that you’re wearing not only makes you a better policeman, but shows you have the skills to help your fellow police,” said HMCS Martin V. Aquino, senior enlisted advisor with the CSTC-A Command Surgeon’s office.

—Story by SSGT Luis P. Valdespino, Jr., USMC, CSTC-A PAO.



LCDR Andrew M. Carter, NC, instructs students in proper intravenous injection procedures. Photo courtesy of CSTC-A Command Surgeon’s Office

NAVY MEDICINE: SAVING LIVES ON LAND AND SEA

Honoring the men and women of Navy medicine is the focus of a collaboration between BUMED and the United States Navy Memorial, marked by a new exhibit, “Navy Medicine: Saving Lives on Land and Sea.”

Surgeon General of the Navy VADM Adam M. Robinson, Jr., dedicated the exhibit as part of the Navy Memorial’s annual Blessing of the Fleet, where he delivered a keynote address on Navy medicine’s global challenges in peace and war.

Using historical images, video, and uniform displays, the exhibit highlights the history and contributions of medical sailors. Individual panels tell the stories of the Medical, Hospital, Nurse, Dental, and Medical Service Corps and their contributions to the Navy and the nation throughout history.

HMCM(FMF) Mark Hacala, a Navy reservist and the Navy Memorial’s historian, created the exhibit. Working



VADM Robinson; HMCM(FMF) Mark Hacala, Director of the Navy Memorial’s History and Education Department; and HMCM(FMF) Laura Martinez, Force Master Chief, open the new exhibit. Photos by Zaid Hamid, U.S. Navy Memorial



A World War II pharmacist’s mate outfitted for sea duty represents the Hospital Corps.

closely with BUMED historians Jan Herman and André Sobocinski, historical images and video footage were compiled to present this inspiring story. Additionally, each of the five corps was asked to identify one of its members to represent the modern face of their corps. These individuals’ images and stories would form the bases of their corps’ display panels.

Selected were NNMC Bethesda trauma surgery chief CDR James Dunne, MC; Hospital Corps School instructor and VCNO Shore Sailor of the Year HM1(SW) Ashley Thomason; family nurse practitioner and recent Afghanistan Bronze Star recipient LT Keith Hoekman, NC; dental surgeon CDR Christopher Stewart, DC; and Aerospace Experimental Psychologist LT Tatana Olson, MSC.

In addition to the exhibit, Navy medicine-themed symposia are being planned for presentation at the Navy Memorial between now and April 2009, one to focus on the Nurse Corps and another on humanitarian assistance missions.

PROUD TO BE AMERICAN

Oppressed people all over the world are inspired by the idea that they may live free from harassment, interference, and persecution. Whether native born or immigrant, every American service person is bound by an oath to defend the nation's constitution and its guarantees of liberty. America's armed forces are the guarantors of President Kennedy's promise to: "...Let every nation know, whether it wishes us well or ill, that we shall pay any price, bear any burden, meet any hardship, support any friend, oppose any foe, in order to assure the survival and the success of liberty."

The armed services reflect America's diversity. Three sailors who emigrated from Africa, HM2 Felix Azunie, HM3 Kinati Feyissa, and HN Emmanuel Busingyenkwizire are now serving with Expeditionary Medical Force-12 (EMF-12) in Djibouti, Africa.

HM2 Azunie was born in French Cameroon and is fluent in French, English, and the Bantu dialect of West Africa. Immigrating to America in 2001 and after completing a BS in biochemistry at the University of Yaounde, he joined the Navy in 2003. HM2 Azunie joined the Navy because "of the opportunity to contribute to the security of the nation after the heart touching September 11, 2001 terrorist attack."

Before deploying to Djibouti, HM2 Azunie was assigned to the pharmacy at the National Naval Medical Center, Bethesda, MD, and was preparing to enter a graduate level pharmacology program. As EMF-12's only pharmacy technician, he is busy filling prescriptions, teaching basic pharmacology, preparing medicine for remote locations, or arranging care for American patients at local French hospitals or other medical treatment facilities. Frequently HM2 Azunie volunteers to assist at the local boy's orphanage when he is not at work.

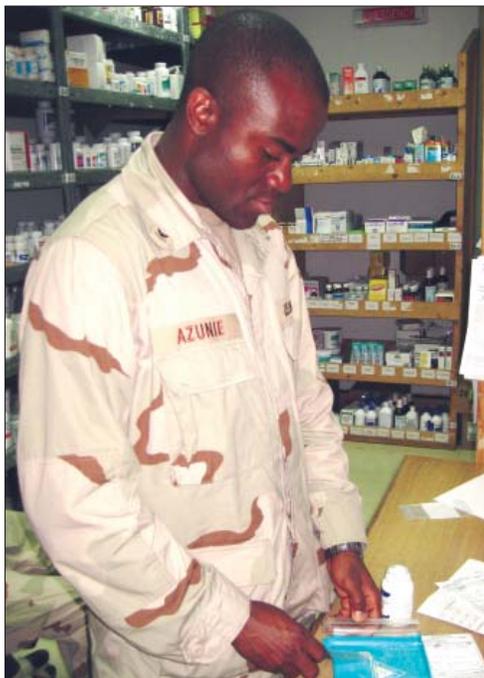
HM3 Kiyata Feyissa is from the Oromia region in Ethiopia. After graduating from Adama University in Ethiopia with a BS in electrical engineering, he immigrated to America in 2003. Since then, he has earned an associate degree in laboratory sciences and enrolled in the medical technology program at The George Washington University.

HN Busingyenkwizire (nicknamed B-15 for the number of letters in his name) was born in Uganda. He came to America in March 2002 where he attended and graduated from Brenkwitz High School, Hayward, CA, in June 2003. In November 2005 he joined the Navy. He is stationed at the Naval Health Clinic in Quantico, VA. In June 2007 he deployed to Djibouti with EMF-11 and while he was deployed he volunteered to remain in Africa for an additional 6 months with EMF-12. B-15 wants to become a physician and is enrolled at the University of Maryland where he is working on a Bachelor's Degree to prepare for medical school.

—Story by HMC(SW/AW/FMF)
Shane O. Chung.



HN Emmanuel Busingyenkwizire



HM2 Felix Azunie



HM3 Kinati Feyissa



CAPT Michael H. Anderson, who has been selected to the rank of rear admiral (lower half), is being assigned as Command Surgeon, U.S. Pacific Command, Pearl Harbor, HI. Anderson is currently serving as Deputy Medical Officer of the Marine Corps, Washington, DC.



RDML Richard R. Jeffries, who has been selected to the rank of rear admiral (upper half), is being assigned as Medical Officer of the Marine Corps, Washington, DC. Jeffries is currently assigned as Commander, Navy Medicine Capital Area/Commander, National Naval Medical Center, Bethesda, MD.



CAPT William R. Kiser, who has been selected to the rank of rear admiral (lower half), is being assigned as Commander, Navy Medicine East/Commander, Naval Medical Center, Portsmouth, Portsmouth, VA. Kiser is currently serving as Chief Medical Officer, Bureau of Medicine and Surgery, Washington, DC.



RDML Matthew L. Nathan is being assigned as Commander, Navy Medicine Capital Area/Commander, National Naval Medical Center, Bethesda, MD. Nathan is currently serving as Commander, Navy Medicine East/Commander, Naval Medical Center, Portsmouth, VA.

PROGNOSIS: JOINT EFFORT NEEDED TO TREAT YOUNG BOY

A local child received potentially life-saving surgery aboard USNS *Mercy* (T-AH 19) on 3 June.

Clarence Dacuycuy was watching television in her home in Cotabato City when she saw a news program about *Mercy's* upcoming visit to the Republic of the Philippines in support of Pacific Partnership 2008. She knew immediately that this was the chance for her to get some help for her 3-year-old son, Jose Angelo.

Angelo suffers from Hirschsprung's disease, which affects the colon. If left untreated, it can result in infections, bursting of the colon, and even death.

On 30 May, Dacuycuy took her son to a Pacific Partnership health screening held at Cotabato Regional Health Center in Cotabato City. At the screening, CDR Stephanie Kapfer, an orthopedic surgeon, knew immediately that the child needed help. "Upon examination it was determined that he had some sort of bowel problem, and I brought him onboard the next day to see if we could provide some treatment," said Kapfer.

Angelo was brought aboard *Mercy* for surgery. His mother was "excited, but nervous" at the prospect of surgery. "He is small for his age. I want him to grow up and be healthy and bigger," said Dacuycuy, "but I have told him about the surgery and that I will be by his side."

One difficulty with this surgery is the follow-on care that is required. Although Angelo requires two more surgeries for full recovery, that didn't stop Kapfer from taking the first step. "When I saw him I knew immediately that this kid was sick and we had to do something, even if it was only the first step in what he ultimately needed to be treated and be normal," said Kapfer.

When it was determined that Angelo could receive treatment aboard *Mercy*, Kapfer called Dr. Lito Chio, Angelo's pediatric surgeon from the Cotabato Regional Medical Center, and asked if he would like to join in the surgery. He agreed, and Kapfer and Chio performed surgery on Angelo. "It was great working with Dr. Choi. He is an excellent surgeon and has a lot of experience. In the operating room, it was the normal surgeon-to-surgeon banter and academic discussion," said Kapfer.

After the surgery Dacuycuy said her son seemed noticeably healthier. "He is more playful now, much improved," she said. "He is restless and wants to go home. He misses his brother very much."

The important follow-on medical care will be provided by Dr. Chio with the assistance of Dr. Andy DeRossi of the 3P Foundation. 3P Foundation is a non-governmental organization which uses humanitarian assistance to promote peace and



Three-year-old Jose Angelo Dacuycuy and HN Daniel Garrett play with a balloon after Dacuycuy received surgery to correct his Hirschsprung's disease. Photo by MC3 Joshua Martin, USN

prosperity among the most disadvantaged sectors of Philippine society.

"3P Foundation will make a donation to Cotabato General Hospital and in return they will make Angelo's operations possible," said DeRossi.

His mother said she is very thankful to Pacific Partnership and the crew of *Mercy* for his new found health. "It is because of the staff of *Mercy* that Angelo is good," she said.

—Story by LT Arwen Chisholm, Pacific Partnership 2008 Public Affairs.



LTJG Catherine Soterias observes as CDR Dale Szpisjak administers anesthetic to one of the patients to be treated aboard *Mercy*. Photo by MCSN Joseph Caballero, USN

EXCERPTS FROM THE WEB LOG OF USS *Boxer*

13 MAY 2008

Onboard *Boxer*, anchored off Puerto Quetzal, Guatemala, several days into our first engagement port. So far, things have been going very well, despite the incredible heat. Temperatures are in the mid-90s, and the heat index is routinely close to 110F. One day it is 111F. The medical care providers and Seabees are absolutely drenched from their own sweat. I cannot imagine how they do it one day, let alone day-after-day....

I talk to an elderly woman who is essentially blind from cataracts. She is in her mid-70s and supremely confident. Her daughter appears a little apprehensive, yet eager to have her mom be able to see again. She enjoyed her helo ride out to *Boxer*. I tell her that when she is done with her surgery, we'll send her back to the beach in a helicopter and get her a window seat, so that she'll be able to see her hometown from the air. The doctor replaces one lens, the other is unable to be repaired. Not an insignificant chore as the ship is rolling around while at anchor, four to five degree rolls each way, all day long, as the swells are not lined up with the winds and the Mighty *Boxer* rolls more than I would have thought. The elderly woman leaves the next day with some vision in one eye. I am sure that her Guatemalan village looked spectacular from the air.

I visit with another elderly woman in the optometry clinic aboard *Boxer*, she is in a wheel chair with long gray braided hair. After a previous surgery in one eye to alleviate her vision problem, she still cannot see out of her left eye. The ophthalmologists cannot repair the eye, however, they fix her up with both regular glasses for her myopia and reading glasses for near vision. Her daughter beams as she explains to me that her mom loves to read and they are both excited that she will now be able to read again.

I visit the main medical mission at Santa Isabel School. I step into the minor surgery clinic where there is a dermatologist working in a classroom. He has a basic set of tools and an elevated cot which is really a field gurney. A 20-something year old construction worker has walked to the clinic and lies on the cot. The doctor pulls out a neurofibroma from the man's chest, a small growth which has been causing him pain.

In a few minutes, the doc is done, and the man walks out, all better. A similar story in room after room, hundreds of times a day.

20 MAY 2008

Onboard *Boxer*, underway off the coast of Puerto Quetzal, Guatemala.

The heat and humidity doesn't let up at all. One day, the docs and dentists experience several heat stress cases. We need to do better keeping them cooled down. However, they are undeterred from their work. "This is what it's all about," they say. "There is no greater reward than seeing a child smile, knowing that you have helped make that happen."

I spend lots of time out on the sites seeing who is doing what. I see a small girl, 2 ½ years old, staying close to her mom. Her name is Katie and her mom is worried because she isn't gaining any weight. Having heard that medical teams were coming to the school, they wait patiently to see a doctor. The doctor listens to their story and provides vitamins for the child. The mother and daughter leave all smiles with young Katie nibbling on sweet bread.

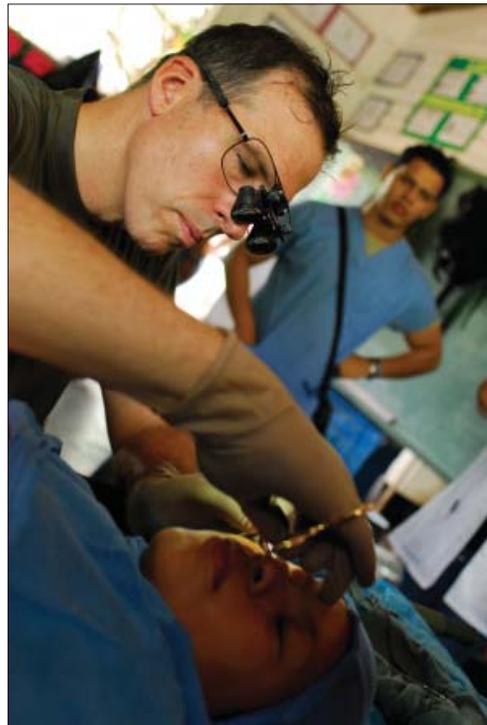
I speak to the dermatologist. He tells me a story about a woman who had a small cancerous growth on her forehead which he is able to take out during a minor surgery. He says she probably would not have had the chance to have it removed if he had not done it. He goes on to relate a story about two children he saw that had a bad skin condition known as scabies. He quickly transcends the language barrier by gloving up and covering them with ointment, and the translator tells the children the follow-on treatment plan to eliminate the painful rash. This type of small success happens every day as the providers continually see smiles and hear lots of "muchas gracias."

We leave Guatemala having done some great things. The doctors have seen over 3,700 primary care patients, the optometrists have seen almost 1,500 patients and handed out over 500 sets of glasses, the pharmacists have dispensed nearly 10,000 medications, the vet team has treated over 500 animals, the surgery team has completed 45 surgeries, and the bio-medical equipment repair team has fixed 14 pieces of critical gear ... all in black flag conditions. I am very proud of this group. ✍

—CAPT Peter Dallman, Commodore, Commander Amphibious Squadron FIVE.



HM1(SW/AW) Raul Huerta cleans the teeth of a Peruvian patient in a makeshift dental chair. Photo by MC2 Joshua Jarvis, USN



LCDR Nathan Uebelhoer removes a mole at the corner of a young girl's eye. Photo by MC2 Joshua Jarvis, USN



LT Megan Rieman, MC, makes a face to get her optometry patient to smile. Photo by MC2 Joshua Jarvis, USN



LT Linsey Miller, NC, drains a cyst for a patient at a medical site in Sonsonate, El Salvador. Photo by SPC Brian R. Williams

After completing a 58-day deployment in support of the U.S. Southern Command's Continuing Promise 08, *Boxer* returned to her homeport, San Diego on 27 June. During this deployment, *Boxer*, with Commander Amphibious Squadron Five embarked, visited Puerto Quetzal, Guatemala; Acajutla, El Salvador; and Huacho, Peru. The medical teams were composed of U.S. Navy, Army, and Air Force personnel, U.S. Public Health Service, and team members from the host nations and from Project Hope and Operation Smile. Project Hope also provided medications. Project Handclasp distributed various other items.



Salvadoran medical patients wait in line to be seen at the Miravalle medical site. Photo by MCSN Matthew Jackson, USN



Bakit, Iraq. HM1 J. L. Knuth examines an Iraqi child's face during a combined medical engagement in Al Anbar Province. Photo by CPL Scott B. Wyatt, USMC



Goubetto, Djibouti. LCDR Allison Crain and HN Kanana Palani prepare to extract a tooth from a local village woman during a Medical Civil Action Project (MEDCAP) in the village of Goubetto. Photo by TSGT Jeremy T. Lock, USAF



Fallujah Surgical, Camp Fallujah, Anbar Province, Iraq. The sign at the emergency entrance speaks volumes (upper left). The sign was erected in 2006 due to the heavy flow of combat casualties in need of blood. The halls remain silent and empty (lower left). The hall was once a frequent stop for combat casualties. Trauma room C has been unoccupied for some time (above).

However, it wasn't always like that. "During the push for Fallujah it was almost every day we had a combat casualty come here. One day the number of casualties outnumbered the staff and we had 115 people on board. I think we had approximately 117 casualties that day. Instead of mopping up blood, we are now mopping up dust," said HMC(FMF) Jose E. Perez. According to reports, May 2008 held the lowest number of coalition casualties since 2004. Fallujah Surgical is no longer treating many injured warriors, but instead is a clinic treating day-to-day injuries. Photos by CPL Stephen M. McGinnis, USMC



Healing the Healer

Cure for the “I Didn’t Do Enough” Blues

James Maddox

I was excited and nervous as I showed up at my Vietnam Marine Corps company reunion back in November 2004. I had experienced something I had never expected to happen, and that was to make contact with one of my field combat wounded patient’s immediate family.

Indeed I had already made contact after three plus decades with some former Marines I had served with as a platoon corpsman (“doc”) with the 3rd platoon, Golf Company of the 2nd battalion, 9th Marines in northern I Corps from mid to late 1968. I had even met the guy who was my first patient in my first firefight. Don’t get me wrong. That occurred in 2001 and it was miraculous in itself. It also helped me tremendously in sorting through some bad feelings and info concerning that particular experience. I had also made contact with others in my unit who shared some of the bad times with me. But what was to come was different and life changing.

In 2004, 35 years after leaving Vietnam, I got an email from one of my 2/9 buddies saying that a person was looking for anyone who may have known her father in ’Nam. I thought it was next to zero that I knew the guy, but I emailed Donna and she sent me back a message describing when, where, and how her father had been wounded. It turned out that I not only remembered him, but had thought of him often, since he was one of those terribly wounded men we treated who

“disappeared.” We never knew what happened to those patients, which was usually the case.

The main reason he stood out so well was the fact that he had really been hit bad but was fortunate enough to have survived the initial blast. That was in early September of 1968. Being an amateur artist at the time, I actually sketched the circumstances when I got back to the rear area. I might add it was the only sketch I made of any of the wounded I treated while in ’Nam.

Peter Paul Serrano was his name, and he was a member of the weapons platoon with my company. They were searching bunkers after a few days of ongoing and deadly fighting in the mountainous ridge lines of northern I Corps. He had set off what was at the time described as a “bouncing betty” grenade. When I got to him he was riddled with holes, large and small. One shocking factor was that all his clothes, except his flak jacket, had been blown off, including his boots and socks. How the explosion didn’t kill him outright or blow his legs completely off is a mystery.

He had a severe left leg wound with a bad compound fracture and jagged bone jutting from the side of his leg. He was bleeding in many areas, but what caught my eye was his penis, which I immediately began to wrap. His crotch was soaked with blood and I could readily see the nasty shrapnel wound in the side of his penial shaft. Later, his medical records showed that

it was 2 by 1.5 centimeters in size. That’s more than ¾ of an inch by more than ½ inch, an extremely large wound for that part of the body.

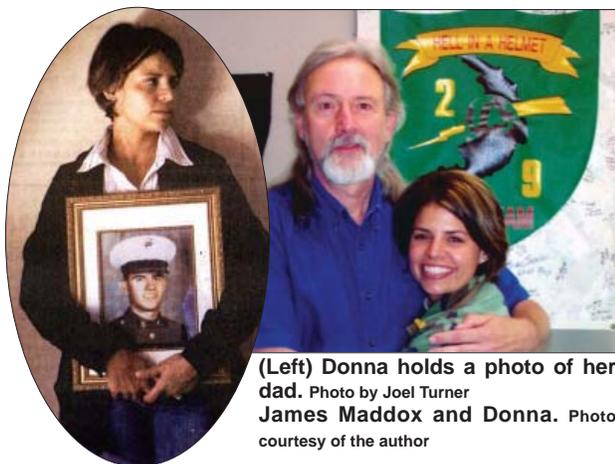
Because another corpsman had come to assist, I think I started treating this particular wound first because had it been me lying there in his predicament, that’s what I would have wanted. I’ve forgotten the exact reason over time, but I think most males would agree.

I proceeded by cutting off and using the strap part of the battle dressing to wind around his penis as I figured the pad would not be tight enough to staunch the flow of blood. The other corpsman, Doc Harms, administered morphine in his thigh. I remember feeling that I messed up for not thinking of doing that sooner myself. I guess I was preoccupied and he wasn’t flailing or screaming in pain at the time.

Peter stayed relatively calm throughout the ordeal, perhaps from shock, and I recall talking with him, probably just to offer assurance. Donna later told me that he asked someone



James Maddox after the operation. Photo courtesy of the author



(Left) Donna holds a photo of her dad. Photo by Joel Turner
James Maddox and Donna. Photo courtesy of the author

where his boots were, as they had gotten “salty” through use and he didn’t want to have to replace them with new ones.

It was not a time to worry about boots. After stabilizing his leg, arm, and multiple other wounds, a few of us placed Peter in a poncho and carried him back up the hill to a place where the chopper could take him aboard. He was flown off the LZ and that was the last I knew of him until contact with Donna.

I’ve mentioned his genital wound several times, and believe me there were plenty of others on his body to choose from, so you can imagine my surprise when I learned Donna was his daughter. One of the first things I said to her was that I was amazed that her father could have children. It turns out he came home and spent a year in the hospital recuperating, and then married his sweetheart, Donna’s mom. They would have two children. But unfortunately, almost 5 years to the day he was injured, Peter died of complications from his wounds. Donna, born, ironically, on 11 November 1970—Veterans Day—was 3, and her brother, Peter, was just a year old.

But she never stopped thinking about her dad, and in the fall of 2004, Donna contacted the 2/9 USMC website and our story began there. When I walked into the room that day and met her, her husband, Rick, and her father’s sister, Aunt Susan, I had no idea my life was about to change, and for the better. I had done what many

combat vets had done after coming home. I shut the war in a place far back in my brain for years. I rarely if ever talked with anybody about the details until I joined a Vietnam group around 1981. Later, in 1987, I went to a 4-month program in Palo Alto, CA.

Even though these groups helped in some ways, I never could get rid of the feeling of being inadequate and that I hadn’t done enough. Or the intermittent fear, anxiety, depression, self-loathing, and very low self-esteem.

Donna and I talked at the reunion and got to know each other. As I was getting ready to go home, she gave me a huge hug, then looked up at me with those big appreciative brown eyes and said, “I love you, Doc.” I felt a chill go through my soul. And when I got home and thought about the slim chances of ever having this happen—meeting someone who was here because maybe I had done enough—was like having a heavy shackle lifted from my heart. I felt better than I had for most of my adult life.

I know I’ll never get over my experiences in Vietnam; that stuff is a life

term. But thanks to Donna’s efforts to find out more about her dad—the U.S. Marine “grunt” who had served and was terribly wounded in that far off place so long ago—I now have a more profound and positive outlook on life. She truly helped me to get a “second wind” as far as the corpsman combat blues. We are still in touch. Donna has a framed copy of the sketch I drew the day her dad was wounded and has it hanging on the wall in her bedroom, right next to the photograph of him in his Marine Corps dress blues. She has become the official honorary “daughter” of my USMC company, and is loved by all.

Now when those intrusive times come, which they still do, and I go to the “bad place” and play mind games with myself about Vietnam and the old didn’t-do-enough-to-save-lives comes barging in, I say to myself, “Don’t buy into it; that’s all changed now.” In this case, I did do enough and I am going to remain damn proud of it. I know there are other docs out there who feel like I did about not “doing enough.” Chances are you did, and more! Thank you, Donna. ✍️

James Maddox was awarded the Bronze Star with Combat V for his Vietnam service. Now semi-retired, he resides in Gibsonsia, PA. You may contact him at jmadd@comcast.net



The author drew this sketch the day he treated Peter Serrano.

3RD MEDICAL BATTALION MEETS IN CHARLESTON

On the weekend of 2-4 May 2008, approximately 90 Vietnam-era veterans of the 3rd Medical Battalion, 3rd Marine Division, gathered in Charleston, SC, for an emotional reunion. This was the Battalion's best-attended reunion to date. The veterans included physicians, dentists, nurses, corpsmen, and Marines, one of the latter who had received life-threatening injuries in Vietnam and was treated at the 3rd Medical Battalion.

The 3rd Medical Battalion deployed to Vietnam in 1965 and served in Danang, Chu Lai, Phu Bai, Dong Ha, and Quang Tri. Thousands of Marines and corpsmen, often brutally injured, received definitive and often life-saving treatment at the medical battalion's various facilities.

CDR Porter R. Halyburton, USN (Ret.), who had been a prisoner of war in Vietnam, delivered the powerful keynote address. His presentation was followed by his wife's moving reflections from a POW spouse's perspective. RADM Thomas R. Cullison, MC, USN, Deputy Surgeon General of the Navy, then addressed the group. During the rest of the day, speakers gave presentations about the battalion's primitive facilities in the early days of Vietnam, the subsequent evolution of more sophisticated facilities, and an eye-opening introduction to the industrialized, tourist-oriented Vietnam of today. The group was then treated to a presentation about how Navy medicine currently supports Marine Corps operations in the Middle East.

Saturday evening, the group gathered aboard the decommissioned USS *Yorktown* (CV-10) moored at nearby Patriot's Point near Charleston, for a formal banquet on the carrier's hangar deck. A number of veterans looked



amazingly sharp in their uniforms. Before the meal, a former Marine Corps sergeant, who had received life-threatening injuries near the Laotian border, addressed the group. Despite hostile fire, he had been medevaced and then treated at a 3rd Medical Battalion facility. His vivid descriptions of those events, and his emotional expression of gratitude to the helicopter crews and medical personnel who saved his life were warmly received.

COL Laura Little, USMC, representing the Commandant of the Marine Corps, delivered an address. She not only reiterated the strong bond that exists between the Marines in a combat zone and the Navy medical personnel who have historically traveled with them into battle, but also expressed deep appreciation for the medical support we had provided.

The reunion was expertly organized by Al Naar, a former hospital corpsman with the 3rd Medical Battalion, and Dr. John Munna, a former 3rd Medical Battalion surgeon.

—Story by CAPT William Mahaffey, MC, USN (Ret.).



During a mission at Hawran, Anbar Province, a Navy commander explains a prescription to members of an Iraqi family. Photo by LCPL Derek Meitzer, USMC

Naval Hospital Bremerton, WA. Feeling "In the Pink..." Approximately 30 staff members and family gathered to join in the "Race for the Cure against Breast Cancer." Their



homemade t-shirts were emblazoned on the back with a "I walk for my Skipper," for CAPT Catherine A. Wilson, who recently underwent a procedure to effectively combat a cancer threat. Photo courtesy of Douglas H. Stutz, NHB, PAO

The Catch-22 of PTSD and a Way to Heal the Pain

CAPT Richard F. Stoltz, MSC, USN

In Joseph Heller's dazzling and outrageous World War II novel, the title *Catch-22*, refers to an insane predicament. Pilots can be grounded from flying combat missions if their doctor considers them to be crazy. However, to be grounded a pilot has to ask to be grounded. Anyone who asks to stop flying combat missions isn't crazy. Therefore, service members fly combat missions whether they are crazy or not.

In the current conflicts in Iraq and Afghanistan there is a psychological health predicament for service members who develop Post Traumatic Stress Disorder (PTSD). What service members' minds need to do to increase their chance of survival in the war zone is the opposite of what their minds need to do to heal from the PTSD they may develop. This *Catch-22* makes it very difficult for service members to admit they have PTSD. And, even when they ask for help, the *Catch-22* makes it hard for them to resolve their symptoms.

A PTSD STORM AND A PSYCHOLOGICALLY HEALTHY COMBAT MIND

All combat situations have the potential to instill PTSD symptoms. The current conflicts in the Middle East are particularly fertile ground.⁽¹⁾ In some armed conflicts, the enemy is wearing a uniform and their location

is fairly well known. There may be less of a need for each service member to constantly be in a state of high alert. However, when any person, including women and children, can be your enemy and when the enemy is often not a person but rather an IED, then survival may depend on maintaining a state of hypervigilance. And, when an IED explodes and kills or wounds fellow service members, there may be no opportunity to shoot back or discharge anger. To avoid getting blown up by another IED, one may need to bury powerful emotions and stay focused on the details of the surrounding environment.

In a combat zone, it is often not safe, wise, or healthy to let oneself get distracted by the brutal events that happened an hour, day, or week ago. Often it is best to block those traumas from present awareness, remain centered on present danger, and carefully scan for IEDs and other hazards. When fears or flashbacks related to previous violence enter the mind, the psychologically healthy thing to do is push them away and concentrate on the perils of now.

THE PTSD MIND

Every case of PTSD is unique. PTSD symptoms can be mild, moderate, or severe. There may be one or many traumas. Recent traumas

may exacerbate earlier traumas that had been submerged for years. Neurological complications or other diagnoses may confound the treatment. In all cases there is at least one traumatic event that is persistently re-experienced in one or more ways (e.g., distressing memories or dreams of the event, feeling as if the event was recurring, and/or distress at exposure to cues that symbolize or resemble the traumatic event). The person attempts to avoid situations and objects that trigger flashbacks or memories of the trauma. Nonetheless, the individual experiences increased arousal such as difficulty sleeping and concentrating. To be diagnosed with PTSD these symptoms must be present for more than 1 month and cause impairment in social and occupational functioning. ⁽²⁾ When service members return home following their deployments to Iraq and Afghanistan they often continue to follow the same psychological strategy that helped them to survive combat. When they experience distressing thoughts, feelings, or images from past traumas, they evade and minimize them. When these intrusive recollections reappear, they persistently do their best to bury them. Their ongoing fight to defeat this internal enemy may lead to substance abuse. In the back

of their minds many of these service members know that in the not too distant future they will again deploy into a war zone.

It is natural and instinctive to attempt to control internal dangers such as anxiety provoking flashbacks. However, in most cases relentless efforts to control PTSD symptoms actually makes them worse. Paradoxically, with PTSD symptoms, one gains control over them by trusting, in a safe and therapeutic environment, that it's okay to stop trying to control the symptoms. Instead, it is best to welcome the symptoms and let them tell a story that is helpful to hear.

A HUMAN SEARCH FOR WHOLENESS AND MEANING

Gestalt Psychology, which developed early in the 20th century, emphasized that the whole is greater than the sum of its parts and that human beings seek to make things whole. When parts are not integrated into a greater whole, people are prone to become frustrated and may attempt to discard the un-integrated parts. Highly emotional pieces from traumatic experiences cannot be easily discarded. When they are shunted aside, they keep coming back, perhaps seeking to be integrated into a greater whole.

Viktor Frankl, an Austrian neurologist and psychiatrist, lived through despicable traumas and went on to have a stellar career, writing many highly acclaimed books that were translated into numerous languages. He survived being an inmate in Nazi concentration camps; his wife, mother, and father died in those camps. In 1946 Frankl's most famous work, *Man's Search for Meaning* was published. In it, Frankl postulated that human beings have a great need to find meaning in their experiences. For him, challenging the meaning of life was the truest expression of being human.⁽³⁾ Traumatic experiences that only display themselves in brief chaotic snippets or fleeting im-

ages do not provide the meaning that many humans crave from the major events in their lives.

In my work with PTSD patients, I have found that PTSD symptoms best resolve when they are viewed holistically and some personal meaning is attached to them.

WAYS TO RESOLVE THE PAIN

In 2007 the National Academy Press published the findings of an Institute of Medicine (IOM) Committee on the Treatment of Post Traumatic Stress Disorder. The IOM committee's thorough review of the scientific literature on PTSD concluded that there was inadequate evidence to support the effectiveness of several forms of psychotherapy treatment for PTSD and for all drug classes being used to medicate PTSD. In contrast, the committee found sufficient evidence to conclude that exposure therapies were useful in the treatment of PTSD.⁽⁴⁾ Exposure therapies generally include psychoeducation, relaxation, and imagined or in vivo exposure to trauma or trauma-like phenomena. While there is much about PTSD that remains unknown and more research is definitely needed, for now "exposure therapy" may be the best treatment we have.

A THERAPEUTIC TECHNIQUE

Approximately 20 years ago, I learned an exposure treatment technique I have successfully utilized hundreds of times with patients who have PTSD. This technique will not work for every patient. Clinical judgment is involved in determining the appropriate use and timing of this technique. It is a powerful tool and should not be utilized without appropriate background and training. It is helpful if the patient understands that what was once important to block from the conscious mind is now best to invite into awareness and purposely explore to heal from PTSD.

There are many variations to this intervention but it primarily consists

of teaching the patient to relax by closing his/her eyes and imagining something that is very relaxing to them.

For example, the patient may enjoy visualizing sitting on the seashore and looking out at the ocean. Sometimes the patient easily learns to relax in this manner; others find this far more difficult. When the therapist believes the patient is ready, the following plan is recommended to the patient. The patient would become relaxed by closing his/her eyes and imagine being at a favorite relaxing place. When ready, the patient visualizes entering an empty movie theater. He/she may go to the theater alone or take a companion. The seats in the theater are very comfortable and the patient chooses where to sit. When the patient is comfortably seated, he/she finds a remote control. When ready, the patient presses play and watches the previously agreed upon traumatic event from beginning to end in as much detail as is necessary to heal from the experience. While in the theater the patient recognizes that the trauma is not happening in the present moment, controls the volume of the scene, and determines whether it is in color or black and white. At all times the patient retains the power to pause, stop, reverse, or fast forward the traumatic scene by using the buttons on the remote control. The technique is only utilized if the patient voluntarily consents to it.

Though most patients consent, almost always watching the traumatic scene is distressing. I have seen patients quickly tighten their fists, turn red, cry profusely, cough loudly, and tremble in fear. In these situations, the patient can be reminded that the scene that he/she is watching is not happening now and that it is being viewed only in as much detail as necessary to heal from it. When the scene ends (usually it takes less than 10 minutes), the patient is requested to stroll down the aisle of the movie theater, walk into the screen, and say whatever they

may want to say to their younger self who survived that trauma. Often compassionate dialogue takes place between the patient and his/her younger self. Without any suggestion from the therapist, they often hug.

Follow up sessions with those who complete this process consistently indicates a great reduction in anxiety provoking symptoms. Sleep greatly improves, flashbacks diminish, avoidance of cues associated with the trauma dissipates. One Vietnam vet, who struggled with PTSD for over 30 years, reported that all his symptoms disappeared. "All of these years, I kept battling my problem. It never occurred to me that I should let myself watch it from beginning to end."

SUMMARY

Thousands of service members deployed to Iraq and Afghanistan

are returning home with PTSD. To prevent this from becoming the chronic mental disorder it has been for many Vietnam veterans, it is critical that we share information and further research efforts. To heal it is helpful to understand the Catch-22 of PTSD. Some patients may only resolve their symptoms if they are able to integrate the trauma or traumas into an overarching tapestry of their life that has a personal meaning for them. At this time it appears that "exposure therapies" offer the best opportunity to help these service members resolve their PTSD symptoms. The "movie theater" technique described in this article is an exposure therapy that this provider has found extremely efficacious.

Footnotes

1. In their article—Hoge, CW, Castro, CA, Messer, SC, McGurk, D., Cotting, DI & Koffman, RL (2004). *Combat Duty*

in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *The New Eng Jour of Med*, 351(1), 13-22—Hoge and his colleagues estimate that approximately 17 percent of soldiers from brigade combat teams are at risk for developing clinically significant symptoms of PTSD.

2. The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association is the standard classification of mental disorders used by mental health professionals in the United States. It lists the criteria for all mental health disorders including PTSD. The latest version DSM-IV-TR was published in May 2000.

3. Though originally published in 1946, *Man's Search for Meaning* remains in print and has been published in numerous hardback and paperback editions.

4. *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*. Committee on Treatment of Posttraumatic Stress Disorder. ISBN: 0-309-10925-6. 200 pages, 2007. 

CAPT Stoltz is Officer-in-Charge of Naval Branch Health Clinic Bahrain.



USS *Wisconsin* (BB-64) ENS Virginia Teti, one of the 14 graduating military medical students from Eastern Virginia Medical School (EVMS), is promoted to lieutenant during their recommissioning ceremony. Photo by MC2 Kitt Amaritnant



HM2 Paul Hurlburt, LPO for the Naval Hospital GTMO's medical readiness and preventive medicine section (left) re-enlists on the floor of the Caribbean Sea off the coast of Cuba. The inducting officer was LCDR Robert Langenfeld (right). Photo by HM2 Patrick Thompson, USN

VADM Ross T. McIntire

Reassessment of an American Hero

Steven Lomazow, M.D.

Ross T. McIntire was personal physician to Franklin Delano Roosevelt from 1932 to 1945. During that time, he rose to the rank of vice admiral and Surgeon General of the Navy. The widespread presently held view of McIntire's performance in that capacity is as an excellent and competent wartime administrator but an abject failure as presidential physician. While the former is undoubtedly correct, the latter could not be farther from the truth.

As a result of intense research which has led to remarkable new insights about the health of Franklin Roosevelt, McIntire emerges not as the incompetent eye, ear, nose, and throat specialist as historians have pictured him, but rather as a masterful head of a dedicated and highly skilled group of physicians, mostly naval officers, who delivered to the president, as well as his close associates, the highest quality of medical care available at the time. Moreover, VADM McIntire was more than a physician to his most important patient; he was an indispensable close confidante and a member of the most inner circle of trusted presidential advisors.

A native of Oregon, VADM McIntire graduated from Willamette School of Medicine in 1912 and joined the Navy as an assistant surgeon in 1917. In 1932, when FDR was looking for a personal physician, he turned to his old friend RADM Cary T. Grayson, who is best remembered as the mastermind of the cover-up of Woodrow

Wilson's massive disability following a stroke in October 1919. Roosevelt befriended Grayson during his tenure as Assistant Secretary of the Navy in the Wilson administration. Grayson, like McIntire, was more than just physician to the president; he was his dear friend, introducing Wilson to his second wife, Edith, and was best man at their White House wedding. Grayson recommended McIntire not only for his competence as a EENT physician, since FDR was subject to frequent "sinus infections," but also because of his ability to "keep a closed mouth."⁽¹⁾

FDR enjoyed generally good health in his first and the early part of his second term. During this time, McIntire accompanied Roosevelt on most of his frequent global escapades, almost always aboard a U.S. Navy vessel. In 1938, the frequency of McIntire's medical treatment markedly accelerated, continuing until FDR's death in 1945. While there is no official explanation for this increased attention, at about this time a pigmented lesion above FDR's left eye first seen in 1923 began noticeably expanding and taking on the characteristics of a highly malignant tumor then known as melanotic sarcoma, one which at the time was a virtual death sentence. In January 1940, in response to an inquiry by a leading gynecological oncologist, Dr. Reuben Peterson, McIntire responded, in confidence, with the only known public acknowledgment of the lesion's existence stating:

"The pigmented lesion above the President's eye is very superficial and has never shown any sign of an inflammatory nature. You can rest assured it is under observation at all times."⁽³⁾

The existence, treatment, and ultimate consequences of the pigmented lesion, known to present day physicians as melanoma, is only now being defined. This remarkable new information also casts additional light on the specific role of VADM McIntire as presidential physician and the high quality of naval medicine in general.

Roosevelt's behavior with respect to his life-defining malady—polio—is a clue to McIntire's role as presidential physician as well. The president applied great energy to conquering polio, devoting the years between the time he was stricken in 1921 until his re-entry into public life in 1928 to undertaking a vigorous program of rehabilitation, seeking out the finest doctors, the most expert information available, and performing intensive personal research into devising specific treatments, earning him the nickname around Warm Springs of "Doctor Roosevelt." He also personally financed the rehabilitation center and even founded a charity later known as "The March of Dimes" to support polio research and awareness. While many biographers continue to believe the later public pronouncements of one of FDR's physicians, Howard Bruenn, that FDR showed little interest in his health, his past behavior is ample evidence to the contrary.⁽²⁾

In sharp contrast, extraordinary measures were taken to minimize the extent of FDR's own disability from the public. Roosevelt's personal battle with polio, as well as any aspect of his health, were matters of the most intense privacy. The press cooperated in this highly orchestrated program of disinformation. Of the tens of thousands of images in existence of Franklin Delano Roosevelt, less than a handful portray him in any physically

compromised way, and none of those were ever publicly released. Any article or news story about presidential health was personally reviewed by the president. The control of the presidential image was so strict that there was even a ban on photographing or filming FDR while he was frowning.

With respect to the White House Staff, including the presidential physician, *any and all information released pertaining to the health of the president was under the direct and strict control of Roosevelt himself. All of Admiral McIntire's public statements about the health of the President, even those after Roosevelt's death in 1945, were made as a result of the expressed wishes of his Commander-in-Chief.* (Author's emphasis)

McIntire was a highly skilled and competent physician within his specialty. He personally treated Franklin Roosevelt on thousands of occasions. None of these records are known to exist, but a 1946 summary by McIntire of his treatment of his assistant, CDR George A. Fox, reflects the highest professional competence employing "state of the art" medications and techniques.(3) McIntire also did not hesitate to call in the finest consultants, such as Dr. Frank Lahey, whom he considered to be America's greatest surgeon. His wartime commissions and advisory boards were manned by a roster of world class medical specialists and scientists.

Roosevelt was treated at Bethesda at least 29 times between 1941 and 1944.(4) The exact nature of these treatments cannot, at present, be determined, but they were directed by the ultimate authority of Dr. McIntire under an extremely tight veil of secrecy.

According to Howard Bruenn's 1970 paper, Franklin Roosevelt was first diagnosed with severe congestive heart failure on 28 March 1944.(5) From this time on Bruenn, chief of cardiology at Bethesda, had only one patient and one assignment: to keep the President of the United States alive. Bruenn convinced a panel of physicians convened by McIntire to employ the use of digitalis, over the initial objection of at least one member, James A. Paullin. When Paullin finally acceded to Bruenn's recommendation, the unpublished notes of Bruenn reveal a fatherly wink of success from the Surgeon General.(6) In fact, all the existing communications between Bruenn and McIntire reflect the highest degree of personal respect and professional cooperation.

On 5 February 1944, less than 2 months prior to Bruenn's alleged "de novo" diagnosis of congestive heart failure, a benign epidermoid cyst or "wen" was removed from the back of the president's head at Bethesda. The primary surgeon was the Navy's chief of plastic surgery, George Webster, assisted by the head naval neurosurgeon, Winchell M. Craig. A recently revealed, reliable letter written by Webster describing the incident indicates that five other physicians, including McIntire, were present in the operating room as well.(7) Webster noted that the president was being treated at the time for a "cigarette cough" and that his first professional contact with FDR was in the operating room on that day, clearly indicating that he was not privy to any other detailed information about Roosevelt's history, likely being chosen for the task by McIntire solely because

Roosevelt Bars Photos Catching Him Unaware

Special to THE NEW YORK TIMES.

WASHINGTON, Feb. 3.—No more intimate photographs of President Roosevelt will be taken when he is unaware of them, under strict regulations laid down by Stephen Early, assistant secretary to the President.

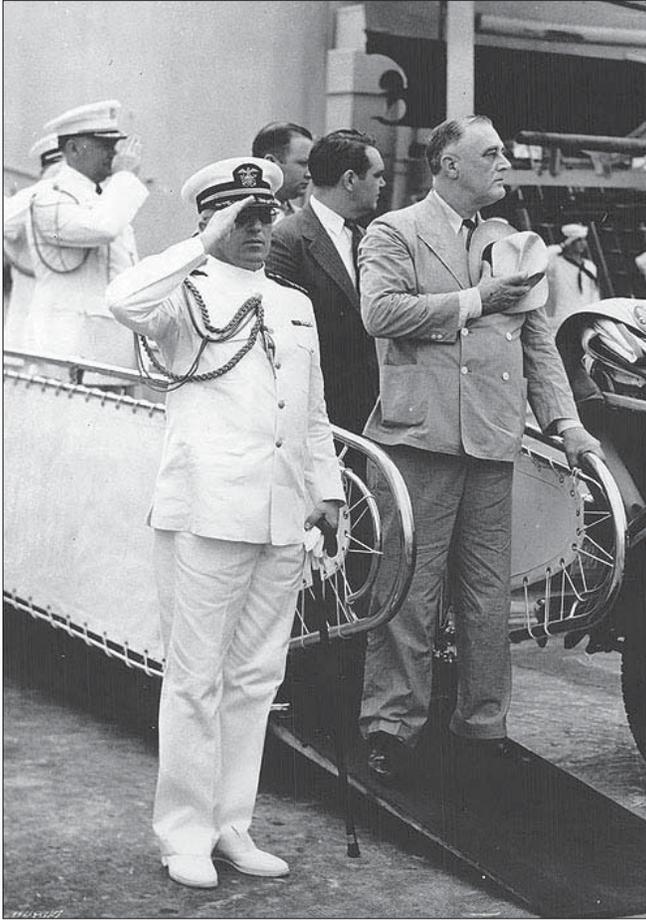
The privilege of photographers to snap pictures at random was revoked primarily because of the recent circulation by a picture agency of a photograph of the President with his hand in front of his eyes to shield them momentarily from bright lights and a caption suggesting that the picture was taken while he was worrying about the agriculture problem.

The new regulations provide that photographers must make pictures simultaneously and only when the President is ready to be photographed.

The rule was invoked for the first time today when photographers made pictures of the new Federal Reserve Board in the President's office. All were required to use tripods.

The New York Times

Published: February 4, 1936
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The president disembarks from USS *Tuscaloosa* (CA-37), February 1940. Naval Historical Center

of his technical expertise. There is little doubt that the president was in cardiac failure at the time. It is unconscionable that this group of distinguished, senior naval physicians was present at the performance of a surgical procedure upon the President of the United States and that none knew of his cardiac status. This would not only reflect poorly upon McIntire as presidential physician, but would also constitute a wholly unrealistic indictment of the quality of Navy medicine itself.

Roosevelt's heart failure was likely symptomatic and known to his physicians long before Dr. Bruenn allegedly first entered the picture. As early as January 1943, Dr. McIntire ordered that the president's plane fly no higher than 8,000 feet on his flight to Casablanca. In early 1944, he was sleeping propped up in bed, a cardinal

between Bruenn and McIntire in 1946 and McIntire's own book confirm that Bruenn had been treating the president for considerably longer.⁽⁹⁾ White House reporter Walter Trohan goes so far as to say that Bruenn was recruited into the Navy specifically to care for the president.⁽¹⁰⁾

Throughout this time, McIntire attributed the president's haggard appearance, frequent, prolonged absence from public view, and canceled press conferences to "influenza" or "a cold" and his weight loss to pride in his "flat tummy." Even after Roosevelt's death in April 1945, McIntire continued to deny publicly the severity and, indeed, the very existence of the president's severe medical problems. His 1946 book, *White House Physician*, written with journalist George Creel, who balked at the speed and quality of

sign of cardiac compromise. Even Bruenn refers to a "history of orthopnea."⁽⁸⁾ When the president's cardiac status had deteriorated to such an extent that his life was in imminent danger and it was deemed that more aggressive treatment as well as a cardiologist's personal, daily, undivided attention was required to keep him alive, Bruenn could no longer be hidden and some acknowledgment of the condition he was treating became necessary for family and those who were with FDR on a daily basis. Letters

McIntire's input, is testimony to his continuing program of disinformation. As late as 1951, when James A. Farley, formerly a close associate of Roosevelt, made some public statements about the severity of FDR's illness, McIntire gave an interview to *U.S. News and World Report* rebutting Farley's claims in typical fashion, even in the face of widespread recognition that Farley's assertions were correct.⁽¹¹⁾ McIntire was, and continues to be, vilified for his lack of candor, interpreted as a combination of incompetence and hubris. Thomas Fleming's excellent 2001 book, *The War Within World War II*, refers to him as a "medical ignoramus."⁽¹²⁾ Nothing could be farther from the truth.

After McIntire's death in 1959, the role of chief protector of the secrets of FDR's health was passed to Howard Bruenn. His 1970 paper in *Annals of Internal Medicine* was written in conjunction with the Roosevelt family allegedly to clear the air of all rumors about the president's health. While it did reveal new details of the severe cardiovascular problems that FDR suffered in the last year of his life, it was indeed nothing more than a more sophisticated and updated document of purposeful deception, timed to divert the impact of a book written by a highly-regarded historian, Hugh L'Etang that credibly raised the possibility that Roosevelt had melanoma.⁽¹³⁾ In 1979, when surgeon Harry Goldsmith presented a similar assertion in a respected medical journal, when contacted by *TIME* magazine, Bruenn flatly denied the president had any form of cancer.⁽¹⁴⁾

In his later years, Bruenn was frequently sought out to discuss his experiences treating President Roosevelt, including a detailed interview by *Navy Medicine* in 1990.⁽¹⁵⁾ To all Bruenn spoke with, he left a distinctly negative impression of his mentor, VADM McIntire. This is highly out of character for the honorable, competent physician and loyal naval officer that Bru-



President Roosevelt and the chief petty officers of USS *Tuscaloosa* February 1940. Naval Historical Center

enn was. The logical inference is that this again was no more than another calculated technique of subterfuge, designed to protect the most intimate secret of his commander-in-chief, the most powerful and charismatic personality of the twentieth century. It would not at all be surprising if McIntire himself had given Bruenn permission to speak as he did in order to protect Roosevelt, knowing that his own reputation as presidential physician was already irretrievably tarnished.

A true reflection of the respect FDR had for McIntire and Navy medicine is well seen in Robert Sherwood's book *Roosevelt and Hopkins: An Intimate History*. Therein is a revealing anecdote about the medical treatment in 1939 at the Mayo Clinic of Harry Hopkins, FDR's close associate, for a severe life-threatening gastrointestinal disorder. It also provides revealing insight into Roosevelt's personality and how he approached an allegedly insurmountable medical problem:

"Hopkins' son, David, was informed at this time that his father had about 4 weeks more to live. And Roosevelt told friends, "The doctors have given Harry up for dead."

Hopkins himself believed that he could not live more than a few weeks. However, Roosevelt proceeded to assume charge of the case himself. Ever

from Rochester to Washington to become a guinea pig for all manner of biochemical experiments; it was a tremendous ordeal, but it was ultimately successful in prolonging a few weeks' margin of life into 6 years of memorable accomplishment." (16)

McIntire himself refers to this incident in his 1946 book:

"Study developed that Harry's trouble came from an imbalance of proteins in the blood stream, and the use of blood substitutes soon helped him." (17)

Dr. McIntire retired from the Navy in 1946. Among his many distinguished subsequent appointments were as Director of the American Red Cross National Blood Bank Program and Executive Director of the International College of Surgeons. He ran unsuccessfully for Congress in 1954.

The truth has now emerged. Ross T. McIntire was a physician of high competence and character and the epitome of the duty and honor of a naval officer, consistently compromising his own personal reputation in order to honor the wishes of his commander-in-chief. His recognition in this role is long overdue.

A 29 January 1945 letter to Albert Q. Maisel from Dr. Frank Lahey, a man not easily given to compliments, about McIntire sums it up well:

intolerant of the defeatist attitude, he indignantly rejected the possibility that Hopkins' life could not be saved. He turned the problem over to the U.S. Navy and Dr. McIntire, who called in Admiral Edward R. Stitt, (former) Surgeon General of the Navy and one of the greatest authorities on tropical diseases. Hopkins was moved

"I do not flatter him in the least when I say I have never known a more completely unselfish individual in such a high and influential position. He wants nothing for himself... Everywhere I go in the Navy, I talk with commanding officers and they all feel as I do, that the Navy and the country is blessed with such a Surgeon General." (18)

References

1. McIntire, RT, Creel, G: *White House Physician*. New York, C.P Putnam's Sons, 1946, p. 58.
2. Bruenn, HG, Clinical Notes on the Illness and Death of President Franklin D. Roosevelt. *Ann Intern Med* 72: 579-571, 1970.
3. Ross T. McIntire Papers, Franklin D. Roosevelt Library.
4. Crispell, KR, Gomez, CF: *Hidden Illness in the White House*. Durham, NC, Duke University Press, 1988; p. 118, FOIA file 81-DFI-1259.
5. Bruenn, p. 579.
6. Howard Bruenn Papers, Franklin D. Roosevelt Library.
7. Goldsmith, HG: *Conspiracy of Silence*; Universe, 2007; pp. 50-53.
8. Bruenn, p. 581.
9. McIntire, p. 27.
10. Trohan, W: *Political Animals*. New York, Doubleday & Company, 1975; p. 200.
11. Ross T. McIntire Papers, Franklin D. Roosevelt Library.
12. Fleming, T: *The War Within World War II*. New York, Perseus Press, 2001; p. 398.
13. L'Etang, H: *The Pathology of Leadership*, Portland, OR, Hawthorn Books, 1970; p. 95.
14. *TIME* magazine, December 17, 1979.
15. Herman, JK: The President's Cardiologist. *Navy Medicine* 81:2, March-April 1990, 6-13.
16. Sherwood, RE: *Roosevelt and Hopkins, An Intimate History*. New York, Harper & Brothers, 1948 p.121.
17. McIntire, p. 94.
18. Ross T. McIntire Papers, Franklin D. Roosevelt Library. ⚡

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BUILDING A SEA-BASED MEDICAL SUPPORT SYSTEM

PART IV: The Rationale for a Unified Medical Support System

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

Articulating a vision of sea-basing as a unified undertaking, a Defense Science Board (DSB) report of 2003 expressed the view that sea-basing should be developed as a joint operational concept. The foreword to the DSB report stated:

“...A central authority must orchestrate the development of sea basing concepts, systems, and concepts of operations. History suggests that sea basing has never been exclusively limited to Navy and Marine operations. The Air Force and particularly the Army must participate in the development and use of this joint military operational capability which lay [sic] at the intersection of traditional special operations forces, Marine, and Army operations. Sea Basing represents a crucial option for future warfare by all the Services, and an important element in the transition between early entry and follow-on operations.”

The report adds that “achieving both inter-operability and inter-modality transfer demands a seamless, rapid and efficient design that is fully joint.” The report further noted that sea-basing must become something more than just the property of the Navy and Marine Corps. “What is crucial to moving the sea base beyond

its Navy and Marine Corps antecedents is the need for other services to tailor their seaborne pre-positioning concepts to the maritime pre-positioning force.” It noted, as an example, the tailoring of part of the Army’s 10th Mountain Division to operate off of a sea base as it did during the Haiti crisis (in that case, the deck of a nuclear powered aircraft carrier) which would substantially increase the nation’s ability to project power from the sea.

CONCERNS REGARDING JOINT EXPEDITIONARY MEDICAL CARE: CAVEATS FOR THE FUTURE

The postulated health care continuum within a sea base includes a minimal medical support structure accompanying ground forces ashore, supported by a notional smoothly functioning medical communications and transportation system. Given the relative paucity of medical regulating exercises and medical communications bandwidth allocated during previous and current operational exercises, major reservations concerning the validity of the sea base plan will certainly arise among today’s military health care providers. Unfortunately, a recent 2007 Government Accountability Office (GAO) report on sea-basing

suggested that a lack of a “unifying vision” still persists within the Defense community, with insufficient joint sea-basing development. Historically, achievement of a unified operational concept for medical support has periodically eluded fruition as well. Two examples are illustrative.

THE UNITED STATES INVASION OF GRENADA

At the inception of the operation on 21 October 1983 after the Commander of CJTF 120 was designated, intensive operational planning was begun for Operation Urgent Fury. Combat support planners, including medical representatives, were not, however, invited participants. Consequently, the logistics estimate of supportability was not completed prior to the execution of the plan, and the required medical support system did not develop. Both the short lead time and the absence of a designated task force surgeon to coordinate medical services at the joint level left medical planners initially on their own. Each service planned within the scope of its organic assets with little or no reference to joint coordination of such activities as casualty care management, whole blood procurement, and aero-medical

evacuation. Erroneous assumptions may have been made as well. For example, the Commander of the 82nd Airborne Division had been informed that both *Guam* (LPH-9) and *Trenton* (LPD-14) had significant medical and surgical capabilities to provide offshore medical support, and that these ships were in the vicinity of Grenada. It is unclear whether this assumption about Navy capability was responsible for his ultimate decision to keep Army medical support to a minimum.

The period of hostilities lasted 96 hours and brought casualties both to *Guam* and *Trenton*. One hundred twenty-three casualties and eighteen deaths were recorded, and the flow of casualties did not always follow a logical or coherent course during their extraction from the island. No significant or sustainable land-based medical asset was established during the hostilities, and there were no established medical triage facilities ashore. Without trained and experienced triage corpsmen or officers, casualties were not sent in an orderly and logical flow to the proper receiving facilities. There were no established medical communication nets between Army and Navy elements, notwithstanding the lack of any between *Trenton* and *Guam*. Likewise, Army helicopter pilots, who were unfamiliar with Navy ships and their profiles, brought casualties to whatever flight deck was most convenient. On several occasions, *Guam* was overwhelmed with both minor and lower priority delayed casualties, while *Trenton*, which lacked any surgical capabilities, laboratory or blood bank, was sent critical casualties. In essence, there were medical assets being both squandered and over-utilized simultaneously in a setting of deficient joint preparation.

BEIRUT 1983

The U.S. Marine compound at the Beirut International Airport was bombed on 23 October 1983.

A terrorist truck bomb carrying 12,000 pounds of TNT detonated at the headquarters of Marine Battalion Landing Team 1/8, killing 241 American servicemen and wounding 112. The tragedy presented an opportunity to evaluate in detail the U.S. military medical system's ability to react to such incidents or, by extension, a larger conflict. Among the principal components tested that day were medical command and control, casualty evacuation, medical regulating procedures, capabilities of facilities, joint medical readiness mechanisms, and the transition from routine peacetime to contingency operations.

Sixty-two casualties were sent to the offshore amphibious ship *Iwo Jima* (LPH-2), which had a surgical team. Several underwent surgery, and one died. A small group was subsequently sent to the British hospital in Akrotiri, Cyprus; 56 others were evacuated on a 4-hour flight, during which an additional casualty died, to distant facilities in Landstuhl, Frankfurt, and Wiesbaden, Germany, as well as Naples, Italy (ironically, bypassing the excellent trauma management facilities in neighboring Israel).

Following the bombing and the ensuing confused casualty management sequelae, a medical review group chaired by RADM James Zimble, MC, evaluated the dysfunctional medical response to the tragedy. While identifying potential problems that fortuitously might be associated with future joint sea-basing, the report noted that there had been no comprehensive plan for the use of those medical assets already in place. As noted by the review, the only mass-casualty plan in place had been that of *Iwo Jima* itself. There had been no effective coordinated theater plan for continuity of care, speedy evacuation, and regulation of victims of terrorist attacks—that is, allocation of each to the most capable treatment facility. The services' contingency plans were described as

“stovepipe documents”—that is, their orientations were purely “vertical,” i.e. intra-service, and they bore little relationship to each other. This was a direct result of the tendency of the services' medical components to support their own line units as if they were the only ones. Since a joint medical staff to arbitrate differences was lacking, there was no existing mechanism for coordinating operations in wartime, or for resolving inconsistencies among the components' plans. The report specifically noted that smoothly running casualty support operations are critical, and a lack of joint planning not only hampers the sharing of limited resources, but also creates confusion over responsibilities. The report likewise detailed serious deficiencies in medical readiness, attributing them in large part to a lack of medical evacuation resources, shortages of equipment, insufficient personnel, as well as inadequate joint planning for wartime or contingency requirements. The shortfalls were attributed to the low priority habitually assigned to medical readiness in the planning, programming, and budgeting process. As the report noted, “Had the ratio of killed-outright-to-wounded been reversed, so that over 200 casualties had required treatment, rather than fewer than 100, the medical system might well have failed.” It recommended greater investment in essential medical readiness resources and refinement of command and control over wartime support and operation of these resources.

Unfortunately, subsequent to both the Grenada and Beirut operations, a Department of Defense IG report indicated that operational plans of the unified commanders-in-chief still did not promote the efficient use or sharing of medical assets. It indicated that the Central, European, and Pacific commands still did not propose to integrate medical support at all, instead assigning each service component to provide care for its own forces only.

Today, if a military force had been deployed from an offshore, dispersed, and geographically isolated strike group and suffered a similar attack, a volume of instantaneously generated casualties of similar magnitude would require prompt and effective care. Any medical treatment system envisioned for geographically distributed sea-based operations must provide more timely and competent treatment and evacuation than was offered in Beirut. Given the unpredictable numbers of casualties produced by modern combat, and the profound severity of survivable injuries inflicted by weaponry currently in use, it must be anticipated that existing forward facilities may be overwhelmed by “casualty overload.” (Even over three decades ago, during the 1973 Yom Kippur War, an Israeli Defense Force evacuation hospital in the Sinai Desert, 20 to 40 miles from the battle lines, received casualties in lots of from 36 to 140, and on one day 440. During the 21 days of fighting the facility treated 4,070 wounded, two-thirds of whom were in shock upon arrival.)

THE SEARCH FOR JOINTNESS: CULTURAL DIFFERENCES

In the opinion expressed by a 2007 Government Accountability Office (GAO) report, individual service initiatives continue to outpace DOD’s articulation of joint sea-basing requirements. These have inevitably led to a lack of coordination, and subsequent redundancy among the service initiatives, medical support notwithstanding. In the eyes of the GAO, in the absence of an overarching joint experimentation campaign plan many sea-basing investigational activities—including war games, operational analysis studies, workshops, technological development, modeling and simulation, platform prototyping, as well as live demonstrations—have taken place across the individual services, combatant commands, and other defense entities without the

ability to evaluate solutions, including medical considerations, and to coordinate efforts. Likewise, it noted that there exists a lack of sufficient modeling and simulation tools available to provide valid data on joint sea-basing. Inevitably, stated the GAO, these will clearly impact upon doctrine and training, as well as any material solutions, such as specific platform prototyping (as, for example, medically supporting the combat wounded).

Unfortunately, cultural differences between the services in the debate over roles and missions are stumbling blocks impeding development of the sea base concept. In light of their own traditional missions, the various services and commands may differ in their view of a notional squadron of large ships gathered at an underway operating base many miles from an enemy shore. For example:

While the Navy views the sea base as a foundation for global presence, strategic access and power projection, the Marine Corps perspective is that of a faster means to deliver a Marine Expeditionary Brigade to the fight. Special Operations Command envisions it as a high-speed mother ship for rapid access, while the Army views the idea as facilitating faster and greater strategic access via their own high-speed, shallow draft connectors to transfer Army troops, vehicles, and gear between the ships and the shore. Indeed, Army leadership may well question how its new plan for reorganizing itself into modular, brigade-sized entities, called units of action, may affect or be affected by the sea-basing concept. It may further ponder how its plans for procuring its own next-generation sealift ships will affect or be affected by the sea-basing concept. (Concurrent with Navy and Marine Corps planning in this arena, the Army is developing its own Joint High Speed Vessel and Joint High Speed Sealift Ships. Indeed, Army planners have conceived of a new type of Shallow Draft High

Speed Ship or SDHSS as a key means to enable operational maneuver from strategic distances. Furthermore, the Army is also in the early stage of development of its own Afloat Forward Staging Base, by adding flight decks to a commercial container ship whose mission would be to provide aerial maneuver to Army forces.)

Although the Air Force may not view the sea base concept as relevant to its core competencies, in reality most of the global connectivity, reconnaissance, navigation, and weather information utilized by the sea services are heavily dependent upon satellites provided and managed by the Air Force. Likewise, sea-based aircraft cannot fly very far inland in Southwest Asia or the Western Pacific without aerial refueling from Air Force tankers. Furthermore, nothing in the current sea-service arsenal remotely approaches the overland persistence of a Global Hawk surveillance drone or the survivability of a B-2 bomber.

THE MISSION

During geographically dispersed or “distributed” sea-based operations in the littorals, the fundamentals for medically supporting critical casualties accrued during joint operational maneuvers must be emphasized. Furthermore, any joint medical support plan must undergo methodical testing of its worthiness, since the allied services may be unaware of all the possible impediments to the rapid surge and timely engagement of their forces in response to crises within a sea-base context. A comprehensive set of goals, performance measures, time lines, milestones, benchmarks, and guidance documents are necessary to manage any joint medical response plan effectively, and to determine if the plan is capable of achieving its goals. Likewise, systematic testing and evaluation of new concepts, an established practice for gaining insight as to how systems and capabilities will perform

in actual operations, must be implemented. Commitment to these most basic fundamentals of medical support in the field must be firmly established.

A HARMONIOUS CONFIGURATION

A “system of systems” approach is therefore required for managing both technical support and logistics within an integrated joint sea base. This composite organizational configuration requires its own unique form of medical systems engineering as well. To ensure connectivity among all the systems and components of the joint sea base, configuration management for medical support is extremely important. Furthermore, a harmonious vision among the joint participants is an absolute prerequisite to facilitate the early and effective application of care to the combat wounded, notwithstanding the fact that during previous eras they functioned independently, utilizing their own unique communications procedures, equipment, logis-

tics, and performance norms. Above all, the structure and operation of the proposed unified medical service for medical support of sea-based operational maneuver must reflect jointly derived requirements for prioritization of medical care, evacuation, and the casualty regulation (distribution) process.

Ultimately, without a well developed joint medical support plan supervised by a joint medical command and control element, and methodical testing of its worthiness, the Navy and other allied services may be unaware of all the constraints that might impede successful surging and timely engagement of their forces in response to crises within a future sea base context. Within this void, however, can be found the opportunity for effectively managing the care required by sick and wounded casualties of future operational conflict. A tri-service medical command and control element would be useful for incorporation within the

combatant command organization of any future sea base: for operational control over joint medical operations, for development and execution of joint medical plans within the sea base, and also for insuring compatibility of the plans of individual components of a joint (or combined) command. Responsibility for control of tactical and strategic components of the medical evacuation system must also be placed within this chain of command, as well as authority to integrate with the joint strategic patient evacuation system. Likewise, it must be responsible for insuring that the system of communications within the joint level, as well as within the various components of the sea base, is sufficient to support wartime medical operations.✍

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Photos taken aboard USS *Iwo Jima* (LHD-7) in 1983. *Iwo Jima* is offshore Beirut Lebanon. She is receiving casualties from the bombing of the Battalion Landing Team at the Beirut International Airport. Pictures were taken first on the flight deck as the casualties were received, and then on the hangar deck as they were being sorted and stabilized. Photos courtesy of author



IN MEMORIAM

RDML Nancy A. Fackler, NC, USNR (Ret.), a leader in the Navy Nurse Corps and Navy Reserves, died in Gainesville, FL, on 29 April 2008. She was 67.

RDML Fackler was born in Norfolk, VA, on 24 January 1941, and graduated from Florida State University with a BS in Nursing in 1962.

She was commissioned as an ensign in the Navy Nurse Corps in 1962, and retired in 1997 with the rank of rear admiral and the position of Deputy Director of the Navy Nurse Corps for Reserve Affairs.

Her career began with a tour on active duty at Naval Hospital Chelsea, MA (1962-1964). In 1967 she volunteered to return to active duty at U.S. Naval Hospital Yokosuka, Japan, where she worked as charge nurse in the intensive care unit caring for severely wounded casualties from Vietnam. Her other duty stations included Naval Hospital Oakland, CA; Naval Medical Command Northwest Region Headquarters Unit; Naval Reserve Health Services Flag Council; and the Naval Reserve Policy Board. RDML Fackler remained in the reserves and continued her education, earning a Masters Degree in Public Administration from Golden Gate University in 1991 and becoming certified in gerontology at the University of Florida in 1994.

In 1996, RDML Fackler was diagnosed with degenerative dementia of Alzheimer's type. Working in gerontology, RDML Fackler was well aware of what the future held for her. Although she recognized that it was too late for her, she nevertheless sought to provide some hope for future Alzheimer's victims by supporting research in this area.

RDML Fackler and her husband, COL Martin L. Fackler, MC, USA (Ret.) donated their house in Hawthorne, FL, to the University of Florida Foundation. The proceeds from the sale of the house were used to found the Nancy A. Fackler Endowment at the University of Florida's McKnight Brain Institute.

RDML Fackler was a member of the American Nurses Association, the National Gerontological Nursing Association, the Alachua County Health Care Coalition, the Naval Reserve Association, the Association of Military Surgeons of the United States, and the Navy Nurse Corps Association.

Her military awards and honors include the Navy Commendation Medal (three awards), Navy Unit Commendation, Meritorious Unit Commendation, National Defense Service Medal, Overseas Service Ribbon, and Armed Forces Reserve Medal. ⚓

Those wishing to remember RDML Fackler, may do so by donating to support research that someday might prevent the disease that took her life. Donations can be sent to:

UF Foundation Records, P.O. Box 14425, Gainesville, FL 32604

(Make check out to: UF Foundation - Nancy A. Fackler Endowment)



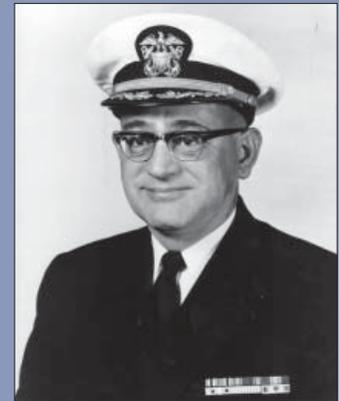
RADM Robert C. Laning, MC, USN (Ret.), died on 28 April 2008.

RADM Laning was born in Cap-Haitien, Haiti on 20 September 1922. Dr. Laning attended the University of Pennsylvania (1941-1943) and received his MD from Thomas Jefferson Medical College in 1948. Following a 2-year internship he joined the Navy in 1950.

Dr. Laning's duty stations included Naval Hospital Portsmouth, VA; USS *Hamul* (AD-20); USS *Intrepid* (CV-11); Naval Hospital Annapolis, MD; Naval Hospital Philadelphia, PA; Naval Hospital Chelsea, MA; Naval Hospital San Diego, CA; Naval Hospital Great Lakes, IL; Naval Hospital Yokosuka, Japan; Bureau of Medicine and Surgery.

In 1961, RADM Laning was assigned to Project Mercury as the senior member of the prime recovery team for the flights of Alan Shepard, Virgil "Gus" Grissom, and John Glenn. Laning served in this capacity until 1964.

RADM Laning's honors include American Campaign Medal, World War II Victory Medal, National Defense Service Medal (with one bronze star), Korean Service Medal, Korean Presidential Unit Citation, and the United Nations Service Medal. ⚓



RADM Rufus J. Pearson, Jr., MC, USN (Ret.), former Attending Physician to Congress, died on 11 May 2008.

RADM Pearson was born in Atlanta, GA, on 8 October 1915. He attended the University of Florida, and received his MD from Emory University in 1938. He then interned at Kings County Hospital, Brooklyn, NY, and completed his residency at Grady Hospital in Atlanta, GA. Years later, Dr. Pearson was trained in cardiovascular diseases by Paul Dudley White at Harvard Medical School. On 13 May 1942, he entered the Navy where he served as a medical officer at the Naval Recruiting Station, Jackson, MS, Armed Forces Induction Station, Hattiesburg, MS, and finally at the Navy Evacuation Hospital int Millford Haven, Wales. With this last assignment, Dr. Pearson worked with Seabees and aided in setting up a dispensary until the end of World War II. Once released from active duty, Dr. Pearson moved to Jacksonville, FL, where he established a private practice in internal medicine.

In 1950, RADM Pearson was recalled to active duty during the so-called “Doctor’s Draft” of the Korean War. His active duty stations included Naval Hospital Jacksonville, FL; Naval Hospital Beaufort, SC; Naval Hospital Bethesda, MD; Naval Hospital Charleston, SC; Naval Hospital Portsmouth, VA.

In 1966, RADM Pearson was selected to serve as the Attending Physician to Congress. Originally established in 1928, for 38 years this post was occupied by one man—VADM George Calver, MC, USN. When sworn in on 27 March 1967 Pearson became only the second physician to serve in this position. During his 6-year tenure, Pearson would serve as physician to over 350 members of Congress. In a 1968 interview with *Parade* magazine, he offered the following assessment: “A congressman has very little time to get off the floor and tear himself away from the heavy load of work. So, I’m here all hours. In a way, though, I’m working for the taxpayers. It costs the government a good many millions of dollars every year to maintain the Congress so we have quite a substantial investment to protect.” Pearson retired from the office, and the Navy, in 1973.



RADM Pearson’s honors include the Armed Forces Reserve Medal; American Campaign Medal; Distinguished Service Medal; European-African-Middle Eastern Campaign Medal; World War II Victory Medal; and the National Defense Service Medal, with star.

Dr. Pearson was a Fellow of the American College of Physicians, the American College of Cardiology, the Scientific Council, the American Heart Association, and was a member of the American Medical Association. 

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Thank you, Janice Marie Hores, Managing Editor

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NAVAL HISTORICAL CENTER

U.S. Navy Ambulance boat No. 1 was built at the Mare Island Navy Yard, CA. The 54-ton, 65-foot wooden-hulled craft was powered by a four-cylinder gasoline engine. Ambulance Boat No. 1 (later YH-1) entered service on 18 August 1919 and served her entire career in the San Francisco Bay area (her two sisters were both transferred to Norfolk, VA, upon completion). She was stricken from the Naval Vessel Register in December 1938 and sold in March 1939.

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