

Navy Medicine

March-April 2007



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NAVY MEDICINE

*Official Publication of the U.S. Navy Medical Department
Volume 98, No. 2
March-April 2007*

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Navy Medicine, (ISSN 0895-8211 USPS 316-070) is published bimonthly by the Department of the Navy, Bureau of Medicine and Surgery (M09B7C), Washington, DC 20372-5300. Periodical postage paid at Washington, DC.

POSTMASTER: Send address changes to *Navy Medicine*, Bureau of Medicine and Surgery, ATTN: M09B7C, 2300 E Street NW, Washington, DC 20372-5300.

Personal subscription address changes: write to *Navy Medicine*, Bureau of Medicine and Surgery, M09B7C, 2300 E Street, NW, Washington DC 20372-5300, or email jmhores@us.med.navy.mil. Include old and new addresses when submitting a change of address to the above.

The Secretary of the Navy has determined that this publication is necessary in the transaction of business as required by law. *Navy Medicine* is published from appropriated funds by authority of the Bureau of Medicine and Surgery in accordance with Navy Publications and Printing Regulations P-35.

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COVER: Surgeon CAPT Kenneth S. Kelleher, MC, USN, practices his healing art in one of NNMC's operating rooms. Painting by Christine Laubach, RN, BSN. Photo by HM1 Stephen Oreski, Navy Medicine Support command, Bethesda, MD.

We Want Your Opinion

Letters to the Editor are welcome. Please let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery (M09B7C), 2300 E Street, NW, Washington, DC, 20372-5300 or jmhores@us.med.navy.mil.

Online issue of *Navy Medicine* can be found at the GPO website <http://permanent.access.gpo.gov/>

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NNMC Nurse-Artist Portrays the OR Experience on Canvas



Nurse Christine Laubach is not content simply with assisting surgeons as they repair the ravages of war. To her the OR is more a cathedral of healing where these gifted physicians practice their art. Her art is capturing their skills and dedication on canvas. “I witness firsthand the unfaltering bravery of the men and women of Operation Iraqi Freedom who come through NNMC, and I am privileged to participate in the many stages of their healing process. As a nurse, I am so inspired by these heroes, both the patients and those who dedicate themselves to making them whole again.

“My recent works include an exploration of unfaltering human bravery, dedication, compassion, conviction, intelligence, focus, and sacrifice. To capture these qualities, I concentrate on the faces, particularly the surgeons’ eyes and gestures. My initial inspiration was a person who exemplified all these qualities, my brother, the late CAPT John E. Smathers, USA.”

Ms. Laubach’s portrait of CAPT Kenneth Kelleher (Cover) is one of several paintings in her series “Faces of the OR.”

“My vision for this series is to explore this human drama of surgeon and patient through black and white oil on large canvas.”



Chief of Naval Operations

CNO Diversity Policy

Diversity is a strategic imperative for the United States Navy.

We defend the greatest nation in the world. It is a nation that welcomes, indeed encourages, the active participation of every citizen regardless of race, gender, creed or color--a democracy founded on the promise of opportunity for all. It is also a nation whose demographic makeup continually changes, reflecting the influx of new immigrants and the growth of minority populations. The Navy must change with it. The degree we truly represent our democracy, we are a stronger, more relevant armed force.

Diversity is critical to mission accomplishment.

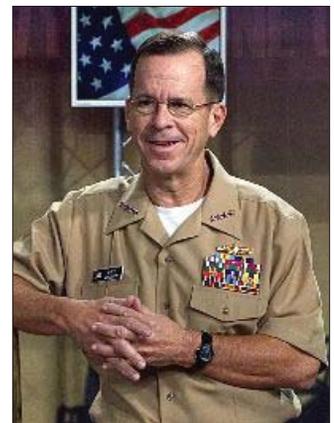
Everyone in our Navy contributes to mission success, and everyone brings to that collective effort unique capabilities and individual talent. How we harness those capabilities and foster that talent bears considerable effect on our ability to successfully accomplish the mission. Like any organization in time of change, we thrive on the infusion of new ideas and the diversity of thought. This is particularly true today, when understanding the mores, customs and ideals of diverse cultures, as well as the perspectives of other people, remains critical to winning the long war.

Diversity is a leadership issue, and everyone is a leader.

We will promote and engender a culture that embraces our diversity. Through our communications, education, policies, programs and conduct, each of us will actively foster work environments where people are valued, respected, and provided the opportunity to reach their full personal and professional potential. We will recruit, develop, educate and retain leaders from and for all parts of our Navy and nation.

We defend the greatest nation in the world. The strength of our diversity directly and irrefutably helps us do so. The Navy will stay committed to improving that strength.

M.G. Mullen
Admiral, U.S. Navy



Bremerton Family Medicine Residency Program Receives Top Marks

There's a Family First news program on a Dallas Fort Worth television station. There's a Family First political party in Australia. There's even a self-help awareness Family First group out of Florida. They all strive to make families their number one priority. Yet perhaps there is no place that takes care of families first and devotes the needed expertise, energy, and commitment than Naval Hospital Bremerton (NHB) and the Puget Sound Family Medicine Residency program.



The highly-accredited and highly-rated program helps handle the medical and healthcare needs of approximately 60,000 active duty service members and eligible beneficiaries, as well as providing top-notch and highly-sought Graduate Medical Education for Family Practice Interns and Residents.

"We're affiliated with the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) Family Medicine Residency Network," explained CAPT Ron Dommermuth, MC, Program Director and Department Head, Puget Sound Family Medicine Residency. "WWAMI is the number one Residency training network as decided by *US News and World Report* ranking of training programs."

There are four other family practice hospitals under the umbrella of Navy medicine located at Camp Lejeune NC, Camp Pendleton CA, Jacksonville FL, and Pensacola FL. Yet it is NHB that most incoming family physicians-to-be pick as their top choice.

"We have had the highest rate of students select us as their preferred place of training over the past 3 years among all five Navy training programs," said CAPT Dommermuth. "Residency program members have a lot of personal drive. For example, the second-year class here had five of six members score 96 on a recent exam, placing in the top five percent in the land. Let's face it, it's sunny down in San Diego and elsewhere but we simply have great resources, great environment, and a great locale. We also have great backing from everyone in the chain of command." According to Dommermuth, each year, there are about six Medical Corps officers who complete the 3-year residency program, which leads to board certification. The focus is on rural medicine, with clinically-strong skills, and training that involves all the major medical disciplines.

"Our overall goal is to produce the best family physicians we can who are capable of handling all the needs of Navy

families and contribute to our Navy mission anywhere in the world," said Dommermuth.

NHB and Navy medicine have a long and distinguished history, from a humble beginning in 1891 on a small gunboat at Puget Sound Naval Shipyard before moving to the present location on Ostrich Bay in 1980. The Puget Sound Family Medicine Residency program was restored and revamped in 1989, which along with the 3-story Family Care Center wing added to the hospital in 2001, has proved to be the perfect venue to train, teach, and treat.

But it's not just the facility itself that attracts. "Our geographic location definitely helps to attract prospective students, as does having full and complete support throughout the facility," Dommermuth commented. "From general surgery to hospitalists, our program is embraced. Everyone is personally interviewed by the commanding officer and asked specifically; 'how can we as a command help. The command really is involved, from the top on down to the grassroots. That tells our people that we want them and that they matter. All our candidates who come here are excited to learn."

"I came here not only because of the great reputation of the program, but also because of the area," said LT Mike McCord, former Navy enlisted petty officer and current Navy Medical Resident in the GME program. "I have felt like part of the overall team since day one. I'm not just a student but a contributing member of the medical staff helping to improve the health of our patients."

McCord is in his final year and then is off to Okinawa. His stint at NHB has included a 2-year "break" where he served on then USS *Camden* as a medical officer before resuming his graduate medical education.

"The exceptional intern program here prepared me for the ship," said McCord, "and completing my residency will have me ready to be a family physician on Okinawa, as well as ready if called to deploy. We also have a substantial group of retirees here, many of whom are World War II, Korean War, and Vietnam War era vets. I have great respect for who they are and what they did and it's an honor to care for them."

"We are part of the future of family medicine," said Dommermuth "Our goal is to essentially manage the medical needs of our patients from birth to the grave. We also want to be specialists in relationships with our patients and all the varied medical systems so we can help facilitate their complete healthcare"

"Our doctors leave with a full tool bag to provide rural family medical needs with a broad package of procedures. They are all skilled in a wide variety of needs, techniques, deliveries, and taskings. They have to be comfortable with what they do, and who they are asked to meet and treat."

The tool bag they take with them might very well be put to use as a general medicine officer who is haze-gray underway, or an embedded doctor forward deployed handling shock and trauma patients. What ever the case may be,

putting family first and improving the health of those they serve will continue to be their mission. 

—Story by Douglas H. Stutz, Naval Hospital Bremerton, Public Affairs.

Navy Environmental Health Center Unveils Entomology Center of Excellence

The Navy Environmental Health Center (NEHC) unveiled its “newest” field activity recently in Jacksonville, FL.

NEHC, in cooperation with the Office of the Secretary of Defense for Installations and the Environment, transitioned the previous Disease Vector Ecology and Control Center in Jacksonville to become the Navy Entomology Center of Excellence (NECE) for the development of new chemistries and application technology tools to better protect deployed forces from insect-borne diseases.

A brand new insectary located in Gainesville, FL, provided the backdrop for the unveiling and will serve as the nerve-center for the vast majority of NECE’s research into control of disease-borne insects.

Congressman Cliff Stearns (R-FL) and Dr. Gale Buchanan, the Under Secretary of Agriculture (Research, Education & Economics) were among many dignitaries on hand for the ribbon-cutting ceremony. Keynote remarks were given by CAPT Gary Breeden, MSC, USN (Ret.).

“The opening of this building is a lasting symbol for the reinvigoration of the past successful cooperative research between these two departments,” Breeden, Program Manager of Medical Entomology said. “All current break-through discoveries for control of disease-carrying insects, used world-



Congressman Cliff Stearns (R-FL) and Dr. Gale Buchanan the Under Secretary of Agriculture (Research, Education & Economics) cut the ribbon opening the doors of DON’s newest insectary. Photo courtesy of Roberto Pereira - USDA

wide, were developed at this USDA laboratory in cooperation with Navy entomologists. Now we can begin producing the next generation of discoveries, enabled by this building, the

largest of its kind in America.”

Insect-borne diseases, such as malaria and leishmaniasis, are on the increase worldwide and more of a threat to deployed forces today than they were 20 years ago. Current products and application methods are decades old and not suited for the high-heat desert environments and insects encountered in the Middle East. New products are sorely needed to ensure military readiness and global public health.

Through NECE, the Navy has been working collaboratively with the U.S. Department of Agriculture to better understand the threat and subsequently develop new and improved products to combat insect-borne diseases.

For more information on the Navy Environmental Health Center and the Navy Entomology Center of Excellence, visit their website at <http://www-nehc.med.navy.mil/main.htm>. 

—Story by Hugh Cox, Navy Environmental Health Center Public Affairs, Portsmouth, VA.



Dr. Gale Buchanan the Under Secretary of Agriculture (Research, Education & Economics) examines mosquito attraction test during a tour of the insectary. Photo courtesy of Roberto Pereira - USDA.

Read any good books lately?

Navy Medicine is 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 this information: 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.

Send submission for consideration to Janice Marie Hores, Managing Editor, at:

jmhores@us.med.navy.mil

I look forward to hearing from you.

DOD and VA Announce Plans for Joint In-Patient Electronic Record System

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) announced plans for the joint acquisition and use of a new common in-patient electronic health record system. The two departments now have separate systems that require upgrade.

Dr. William Winkenwerder Jr., Assistant Secretary of Defense for Health Affairs, said, "I am very excited by the prospect of adopting a common, mutually beneficial solution to our in-patient health documentation needs. This collaboration is a further extension of the highly successful partnership we have established with the Department of Veterans Affairs, and is another example of the commitment our departments have made to work hand in hand to provide continuity of care for our beneficiaries."

Both VA and DOD have been independently working on the enhancement and improvement of their respective inpatient electronic health record tools. AHLTA, DOD's electronic health record (EHR) is implemented worldwide and currently supports the documentation and management of outpatient healthcare for nearly 9 million beneficiaries. Management of inpatient care is a future capability planned for AHLTA. The VA is planning to modernize VistA, its electronic health record, including its inpatient module. Common need and the potential benefits led the two departments to discuss the feasibility of jointly implementing a common inpatient electronic health record.

Despite obvious differences in mission, such as DOD's requirements to support its combat theaters, pediatric and obstetrical patients, and VA's requirements to support domiciliary care, both agencies believe that the similarities in clinical and business processes may make the adoption of a common inpatient EHR a viable option.

Jim Nicholson, Secretary of Veterans affairs, who announced plans for the joint venture at a meeting of the American Health Information Community, called the agreement "groundbreaking" and said "it has the potential to further transform the way we care for our nation's veterans and active duty service members."

DOD and VA have made tremendous progress in their ability to share electronic health information as they move toward achieving interoperable electronic health records. Millions of records and data messages are already regularly transferred electronically between the two organizations. The success of their efforts has placed them at the forefront of the national effort to share health information.

Adopting a joint electronic solution for the documentation of in-patient health information will facilitate the seamless transition of active duty service members to veteran

status. It will also make the inpatient healthcare data on shared beneficiaries immediately accessible to both DOD and VA healthcare providers. An added benefit of adopting a common tool is the potential for both agencies to realize significant cost savings through a joint development or acquisition effort.

Both agencies have agreed to conduct a study to examine their respective clinical processes and requirements and assess the benefits and the impacts on each department's timelines and costs prior to a final decision on a joint acquisition strategy for an inpatient EHR. 

—U.S. Department of Defense, Office of the Assistant Secretary of Defense Public Affairs,

NAVMED MPT&E Supports Council on Occupational Education Conference

Navy Medicine Manpower, Training and Education Command (NAVMED MPT&E) was represented by the command's supervisory instructional specialist during a joint panel discussion at the Council on Occupational Education (COE) conference in Atlanta, GA, November 2006.

Dr. Laurel Myers, Supervisory Instructional Systems Specialist, NAVMED MPT&E, joined representatives from the Army Management Staff College and the Defense Acquisition University to help participating DOD professional and technical schools ease the process of the COE self-study and accreditation visit. The self-study and accreditation visit is a program designed to help DOD schools prepare for academic accreditation.

"The COE is the national education accrediting agency the armed forces work with to, in part, help service members be more competitive for jobs when they leave the military," said Myers. "If a sailor graduates from an accredited military school and the school uses an additional accrediting body which assigns recommended credits by course, then the sailor can apply for those credits to go toward a college degree," she stated. "Skills learned in the Navy course can also give the sailor a competitive edge in the job market over others who have not been trained by a school accredited by the COE."

DOD requires all schools, including those under NAVMED MPT&E, to meet the standards of external accreditation. Myers said the message shared with the DOD schools at the COE conference was that schools do not need to go through the self-study in a vacuum. Help is available.

"The information we presented not only allows schools to be armed with background information to help them plan their self-study, but it also provides a helpful website for schools with little or no experience," said Myers.

The self-study and accreditation survey website is available for schools to use to share lessons learned to help each other

through the sometimes difficult process, she said. The COE web address is www.council.org.

After the conference, Myers stated that the comments received from COE conference participants indicated the information on the website has been very helpful. "In fact, a conference representative mentioned that she posted her entire self-study on the website so that it can be used by others as a guide in the creation of their own self-study report," she said.

According to Myers, the coordination of lessons learned will benefit schools across DOD and allow for strong colorations across organizations to meet the requirements of the COE self-study and accreditation visits. This process also brought the NAVMED MPT&E name to the forefront as a partner in guiding schools to the information sources that are available to help them through their COE self-studies. 

—*Navy Medicine Manpower, Training and Education Command Public Affairs and Navy Medicine Support Command Public Affairs.*

Task Force on Future of Military Healthcare Established

Deputy Defense Secretary Gordon England announced the names of the 14-member future military healthcare task force. The task force will evaluate and recommend alternatives to insure the availability and affordability of military medicine over the long term.

As directed by Congress in the National Defense Authorization Act for 2007, the task force will include seven members from within the department and seven experts from a variety of disciplines external to the department. Task force members are identified in the next column.

"The military health program has many important challenges, the most critical being the rapidly growing costs of health benefit coverage," said England, "and the need to make adjustments so this great program can continue far into the future. We in the department and in the Congress look forward to the task force's recommendations."

The task force has a slate of objectives that includes assessment and recommendations on wellness initiatives, education programs, accurate cost accounting, universal enrollment, system command and control, procurement adequacy, military and civilian personnel mix, Medicare-eligible beneficiary needs, efficient and cost-effective contracts, and the beneficiary-government cost share structure to sustain military health benefits over the long term. This cost sharing structure has significant priority in that the task force must report on this element in both the interim and the final reports.

Vice Chairman of the Joint Chiefs of Staff ADM Edmund Giambastiani Jr. stated, "Military medicine is unmatched anywhere in the world. Our troops know they have the best

care should they need it, and they know their families at home have the same great care. As the leaders of this department, we have the responsibility to ensure this excellent healthcare continues for future generations of soldiers, sailors, Marines, and airmen and their families."

Task force membership resulted from considered coordination with the secretaries of the military services and inter-agency leaders. The defense secretary will receive the interim report of the task force in May 2007, and the final report in December 2007. Following review by the secretary, the report will go to the Armed Services Committees of the Senate and the House of Representatives.

"The task force represents a broad group of individuals with outstanding expertise and knowledge of healthcare generally and also of military healthcare," said William Winkenwerder Jr., Assistant Secretary of Defense for Health Affairs. "The group is bipartisan and includes recognized experts in quality, health benefit design, costs and actuarial projections, women's health, organization and delivery of healthcare, and national health policy. This is an impressive group of thoughtful and experienced people who care about military healthcare. We look forward to supporting their efforts, and I welcome their recommendations."

Task Force Members

Department of Defense Members:

Air Force GEN John D. W. Corley, vice chief of staff, Headquarters U.S. Air Force

Retired Army MGEN Nancy Adams, former commander Tripler Army Medical Center and acting director, TRICARE Regional Office, North

Navy RADM John Mateczun, Deputy Surgeon General

Air Force LGEN James Roudebush, Surgeon General

Air Force MGEN Joseph Kelley, deputy director of logistics for medical readiness, the Joint Staff

Shay Assad, director of defense procurement and acquisition policy, Office of the Undersecretary for Acquisition, Technology and Logistics

Retired Air Force GEN Richard B. Myers, former Chairman of the Joint Chiefs of Staff

Non Departmental Members:

Robert J. Henke, Assistant Secretary for Management, Department of Veterans Affairs

Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, Department of Health and Human Services

Gail R. Wilensky, Ph.D., elected member of the Institute of Medicine of the National Academies and its governing council

Robert F. Hale, senior fellow at the Logistics Management Institute and member of the Defense Business Board; formerly Assistant Secretary of the Air Force for Financial Management and Comptroller

Army Reserve MGEN Robert Smith, past president and current member of the Board of the Reserve Officers Association, and global controller, Vehicle Service & Programs, Ford Motor Co.

Larry Lewin, founder of The Lewin Group and currently executive consultant on clinical and technology effectiveness, health promotion.

Dr. Robert Galvin, director of global healthcare for General Electric.

Patient Care System Aims to Reduce Medical Errors

The Department of Defense has trained thousands of military healthcare providers to employ a quality management system that's designed to minimize human errors in hospital operating and delivery rooms, a senior defense official said.

The Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program stresses teamwork and communication among doctors, nurses, and other healthcare providers to improve quality, safety, and efficiency across military healthcare, Dr. David N. Tornberg, Deputy Assistant Secretary of Defense for Clinical and Program Policy, said during an interview with the Pentagon Channel and American Forces Press Service.

"Providing the optimum, cutting-edge care to our beneficiaries is what this is all about," he said. "I'm proud to say that the Department of Defense and the military healthcare

system are absolute leaders in enhancing a culture of safety in our military treatment facilities."

Use of TeamSTEPPS creates "an environment where people broadly communicate and have a clear understanding of the goals and objectives of the team," Tornberg continued. "Establishing a culture of patient-centered care through the use of teamwork and enhanced communication among healthcare employees is absolutely vital. Miscommunication clearly is associated with medical errors."

More than 5,000 healthcare givers at more than 80 military treatment facilities in the continental U.S. have received TeamSTEPPS instruction in the last 3 years. And now, about 1,000 trainers and coaches are teaching the concept at other military hospitals and clinics. The program has been 'incredibly well-received' by military healthcare givers, Tornberg continued.

"The training system was developed from more than 20 years of experience in the aviation, military, nuclear power, healthcare, business, and other safety-conscious industries," Tornberg said.

DOD is now collaborating with the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality to make TeamSTEPPS available to the public health care industry."

The military health system operates 72 hospitals and more than 500 medical and dental clinics administering care to more than 9.3 million beneficiaries, according to DOD documents.

—Story by Gerry J. Gilmore, American Forces Press Service, Washington, DC.



On 19 September 1950, a Douglas R5D "Skymaster" en route to Japan crashed at Kwajelein, Marshall Islands. On board were 26 Navy officers, including 11 Navy nurses—all of whom lost their lives in the accident. The tragedy marked the largest loss of nurses in history. A memorial to the victims was unveiled on Kwajelein in mid-February.



Okinawa, Japan. VADM Donald C. Arthur, far right, and Commanding General III Marine Expeditionary Force, LTGEN Joseph F. Weber, far left, join Naval Hospital Okinawa Commanding officer CAPT Peter F. O'Connor, and LCDR David W. Hardy, head of pharmacy services, for a ribbon cutting to commemorate the official opening of the newly remodeled pharmacy at U.S. Naval Hospital Okinawa. The new state-of-the-art facility is the result of a \$4.1 million dollar renovation project to expand and upgrade pharmacy operations at the hospital. November 2006. Photo by Brian J. Davis

Risk Communication Training to Be Featured at

Navy Occupational Health and Preventive Medicine Conference

Risk Communication training will be featured at the 46th Navy Occupational Health and Preventive Medicine Conference, held at the Hampton Roads Convention Center, Hampton VA, from 17–22 March 2007.

Originally intended to provide environmental health professionals with the tools necessary for communicating environmental and occupational health risks to Navy and Marine Corps personnel and the general public, Risk Communication has begun to partner with the Public Affairs community to further enhance its ability to “deliver the message” to stakeholder worldwide.

The Risk Communication training intended for both environmental health and military public affairs professionals will be held March 21st and 22nd. RADM Smith, Chief of Naval Information, is scheduled to deliver the keynote address for the Risk Communication track. Environmental Health and Risk Communication subject matter experts from Army and Navy as well as Mr. Guy Schein, Public Affairs Officer for Navy medicine are among the scheduled guest speakers offering attendees an interactive and multi-disciplinary approach to Risk Communication.

For more information on the Navy Occupational Health and Preventive Medicine Conference, visit the Navy Environmental Health Center website: <http://www-nehc.med.navy.mil/Conference07/Index.htm>

In order to participate, attendees must create an account online and register for the Risk Communication Case Studies.

Champions of Operational Readiness Training

The Naval Operational Medicine Institute (NOMI) is a subordinate command of the Navy Medicine Manpower Personnel Training and Education Command. NOMI functions as one of the Navy’s most dynamic commands with a mission of providing a tactically proficient, combat credible naval medical force providing optimal force health protection to support the joint war fighter at any time and any place, along the full spectrum of operations. With training components geographically dispersed across the country, NOMI supports the largest training throughput in Navy medicine with roughly 25,000 students trained annually. As stated by NOMI’s CO, CAPT Barney R. Barendse, “NOMI supports the joint war fighter through employment of state-of-the-art resources, medical knowledge, and research in order to provide exceptional educational and training as the foundation for Force Health Protection.” NOMI is recognized as the proven expert in aviation survival training, undersea medicine, surface warfare medicine, aerospace medical physical standards, aerospace medical disposition, aerospace education, fleet hospital operations, operational medical lessons learned, and prisoner of war studies.



As part of the NOMI Headquarters staff located in Pensacola, FL, and the only medical lessons component in Navy medicine, the Naval Operational Medical Lessons Learned Center (NOMLLC) mission is to collect, review, validate, and disseminate key observations, insights, and lessons involving medical support. NOMI has been designated by the Chief of Naval Operations (CNO) as a Warfare Center of Excellence. In this capacity, NOMLLC collects and disseminates information by identifying significant issues and providing feedback to all operational medical activities to improve Navy medicine readiness in support of the joint war fighter, situational awareness, and health service support readiness. Lessons learned submitted via active collection, passive collection, or direct reporting from medical support of operational missions are systematically captured and integrated into concept development to generate new tactics, techniques, procedures, and doctrine. Lessons learned will also serve as principal sources for the design of future Navy medical education and training curricula, courseware, training events, and execution of medical operational support of the war fighter. Captured observations, after action reports, and lessons learned can be input through both Non-secure Internet Protocol Router Network (NIPRNET) and Secret Internet Protocol Router Network (SIPRNET) websites with the objective of sharing knowledge to highlight both positive

and negative experiences and to provide change agents input for resolution to identify gaps.

The Robert E. Mitchell Center for Prisoner of War Studies is also part of the NOMI. The Mitchell Center evaluates former prisoners of war from all services, as well as their experiences both in captivity and through repatriation and reintegration into society, so that these lessons learned may be used to help others in future conflicts. The goals of the Center were originally established by CAPT Robert E. Mitchell, a Navy flight surgeon, and continue today as a result of congressional funding that led to establishment of the Center with ongoing support.

Formerly known as the Fleet Hospital Operations and Training Center (FHOTC), the Naval Expeditionary Medical Training Institute (NEMTI) is located aboard Marine Corps Air Station Camp Pendleton, CA, and is evolving into the Center of Excellence for the training of Navy deployable, shore-based healthcare facilities. NEMTI provides all field training on the assembly, disassembly, establishment of command structure, and basic operations of a Navy Fleet Hospital to personnel assigned to fleet hospital billets. NEMTI also provides and hosts “theater specific” training for personnel currently deploying in support of Navy Fleet Hospitals and Expeditionary Medical Facilities and serves as the Navy’s field test and evaluation center for deployable medical systems equipment and doctrine.

The Naval Survival Training Institute (NSTI) was established on 1 October 2002, and includes a headquarters element located at Naval Air Station Pensacola, FL, and eight Aviation Survival Training Centers geographically dispersed across the country. The primary mission of the NSTI is to provide safe, effective, fleet relevant aviation survival and human performance training in order to meet CNO operational training requirements. NSTI is responsible for the development of Naval Aviation Survival Training Program (NASTP) curricula, training standardization, and safety, and also validates new and modified survival equipment configurations. It also establishes training and egress procedures for Naval Air Systems Command and other joint organizations. NSTI provides high-risk aviation survival training to approximately 23,000 personnel annually.

The Naval Aerospace Medical Institute (NAMI), located in Pensacola, FL, is the world leader in aerospace medical qualification and education, with a mission to provide professional and technical support, aeromedical disposition, and consultative services in operationally related naval medical matters worldwide. Education and training programs for medical department personnel in various operational medical disciplines including aerospace medicine, flight surgery, aerospace physiology, aerospace experimental psychology, aviation optometry, and aerospace medical technicians are provided to over 200 joint and international students annually. NAMI is accredited by the Accredita-

tion Council on Graduate Medical Education as a BUMED (M7) campus.

Located at Naval Submarine Base Groton, CT, the Naval Undersea Medical Institute (NUMI) provides training and technical support in undersea medicine, radiation health, and related matters, to meet the requirements of Navy medicine and to provide technical support in those matters to naval operating forces worldwide. NUMI provides training for submarine independent duty corpsmen, radiation health technicians, undersea medical officer candidates, and radiation health officers. NUMI also provides the Navy’s only Radiation Health Indoctrination Course for officers and enlisted personnel ordered to a wide variety of billets throughout the fleet. Staff members field calls from military activities all over the world on matters related to radiation health, undersea medicine, and submarine medical administration.

Located in San Diego, CA, the Surface Warfare Medicine Institute (SWMI) supports operational medical readiness for the surface forces through training, consultation, and resource publication. Courses include Commander, Amphibious Task Force--Surgeon Course (CATF-S), Surface Warfare Medical Officer Indoctrination Course (SWMOIC), Surface Warfare Medical Department Officer Indoctrination Course (SWMDOIC), Operational Medicine Symposia (OPMED), and Medical Augmentation Program Training (M+1 Training) for Casualty Receiving and Treatment Ship Augmentation Teams.

The Naval Special Operations Medical Institute (NSOMI), located at Fort Bragg, NC, was established on 1 October 2006, and is the sole source of medical training for Special Operations Forces (SOF) medics, technicians, and corpsmen under U.S. Special Operations Command (USSOCOM). NSOMI is the Navy Detachment within the Army Joint Special Operations Medical Training Center (JSOMTC) and offers training courses in Special Operations Combat Medic, Special Operations Independent Duty Corpsman, and Special Operations Combat Medical Skills Sustainment.

NOMI is a unique command providing operational medicine education and training, consultative services, and aviation survival training in direct support of the joint war fighter in all warfare disciplines. Truly a force enabler, NOMI is manned by proud professionals that continue to ensure the sustainment of a fit and healthy force in order to aggressively prosecute the Global War on Terrorism and achieve all Department of Defense objectives.

To learn more about NOMI and its training components visit their command website at <http://www.nomi.med.navy.mil/index.htm>. To register on the Naval Operational Medical Lessons Learned Center website go to <https://www.mccll.usmc.mil/nomi/index.cfm>.

Nurse Corps Communication Team Gets the News Out

With a community that stretches itself across the globe, the Navy Nurse Corps (NC) is continuously working to create new and improved ways to share information in a timely and efficient manner with its members. The NC Communication Team was established in the fall of 2006 for this purpose.

“RDML Christine Bruzek-Kohler, Director, NC, met with senior leaders back in August 2006 to establish the priorities of the corps. Communication was a major topic of this meeting. Senior leadership was concerned that official, efficient, and timely information was not being shared within the community and they wanted to rectify this situation. From this meeting the NC Communication Team was born,” said LCDR Newton Chalker, Corps Chiefs Action Officer.

The team is comprised of 24 members. These members are responsible for six cornerstone products: NC admiral’s regional senior nurse executives’ call (every 2 months), Admiral’s all NC community VTC (every 6 months), NC news live, newsletter (weekly), web homepage, and email groups.

According to Chalker, every 6 months the Director will hold a video teleconference (VTC) all hands call. This will provide corps members the opportunity not only to see and hear the key messages the admiral wishes to share, but also allows time for a question and answer session. For those members who are unable to attend the VTC, the meeting will be recorded for rebroadcast on the NC web homepage. The next VTC is scheduled for March 2007.

The NC web homepage (<https://wwa.nko.navy.mil/portal/splash/index.jsp>) has been in existence for some time. As with any product, the NC felt it was time for a change in the website. “With the idea of providing up-to-date and useful information, we took a deeper invested interest in how our website not only looked, but also in how we are going to present that information to our community and to the public,” said Chalker.

He continued, “Ownership of information is key in providing the most useful information for that particular community. The corps has several communities within the overall community and we found that when a specific community, say Reservists, has ownership of their web page, they take pride in it. They want to put their best foot forward and provide the type of information to their community that will be of most use. Also, each web page provides a point of contact information to the community. If you have a question or comment about a particular community web page, you have access to a person who can assist you.”

One of the more innovative creations of the communication team is the NC News Live web cast. “This is a live,

dial-in show that allows our members to call in, ask questions and discuss topics of interest,” said Chalker. “The show is broadcast on the NC website and has been a huge success. Our next show is scheduled for 15 January and will be both audio and video. We record each show and provide a link to the recording just in case someone misses the live show, but won’t miss out on the information.”

For community members who prefer a paper information format, the NC newsletter will suit your taste. “In this day of technological advances, people still like to have printed materials to receive information,” said Chalker. “This is where the NC newsletter comes in. The newsletter is published every week and is available online at the website for members to download and print. Only official NC news and information is printed in the newsletter. Along with that information we also provide a section to highlight the good things individual folks are doing, our Bravo Zulus.”

The information provided by the communication team is available to all members of the community—officers, hospital corpsmen, and civilian and contractor personnel.

For more information about the NC Communication Team and its products, contact LCDR Chalker at njchalker@us.med.navy.mil.

—From Bureau of Medicine and Surgery Public Affairs, Washington, DC.



Fleet Surgical Team 5 performs laparoscopic surgery aboard the amphibious assault ship USS Boxer (LHD-4) while on station in the Persian Gulf. Photo by MC Paul Polach, USN

SimMan Joins Amphib Fleet to Revolutionize Medical Training

Expeditionary Strike Group 5 (ESG) recently introduced a Simulated Man, or SimMan, a revolutionary training mannequin for use in casualty training scenarios. According to CDR Michael A. Nace, Deputy Group Surgeon for Commander Amphibious Group (CPG) 3, the SimMan is a major step forward in preparing deck plate sailors and medical personnel alike in emergency life saving procedures. “It can be used to train, educate, and reinforce the capabilities of the entire medical department,” said Nace.

According to the manufacturer, SimMan’s natural physique, simulated vital signs, and internal body sounds combine with functionality to make this advanced patient simulator ideal for training on everything from intravenous (IV) needle insertion to realistic practice of chest tube insertions.

The ultimate goal of SimMan is improving medical training and response to casualties across the ESG, from top to bottom. “Everyone from the basic stretcher bearer to the surgeons can benefit,” Nace said.

LT Rhonda Bennett, Fleet Surgical Team (FST) 9’s critical care nurse, said SimMan’s humanlike features allow trainers and trainees alike to practice IV injections in the replaceable IV training arm, take vital signs on a simulated pulse at multiple points on the body, and simulate clearing the mannequin’s realistic airway. “The lifelike features make the in-theory part of training virtually disappear,” said Bennett. “SimMan is so realistic it is almost like training on a real

person. We no longer have to train in theory or on lifeless mannequins. This is real life hands-on training.” According to Bennett, the multi-faceted capabilities of SimMan create a training environment far more advanced than what was available on previous training mannequins. “This is an exciting new way to train,” she said. Bennett recently completed a SimMan training program in Sarasota, FL. “We can now train in real life scenarios that will better equip every sailor to be first responders to medical emergencies.”

The ultimate goal for Nace, the ESG and the fleet is for SimMan to increase medical readiness across the waterfront. “The technological advances have made this level of training available to all hands and will be available for a variety of training environments,” he pointed out.

“The training possibilities are unlike anything we have seen in previous training mannequins,” said Nace. SimMan provides realistic training feedback previously unavailable on earlier model training aids.

HM2(SW) Nathan Hagman, a bio medical technician aboard USS *Bonhomme Richard* (LHD-6) (BHR) which recently acquired SimMan, said the integrated computer system continually monitors the treatment conducted on SimMan and generates multiple real time and after action reports.

The SimMan computerized training mannequin is currently in use across the military and has been integrated into the training curriculum at hospital corpsman “A” school at Navy Hospital Corpsman School, Great Lakes. The BHR medical staff expects to provide training utilizing this revolutionary device to ships across the ESG starting early next year. ⚓

—Story by MC2 Dustin Mapson, USS *Bonhomme Richard* (LHD-6) Public Affairs.



COL David Schall, European Command (EUCOM) Surgeon General, hosted a quarterly Component Surgeons conference at the Navy Europe (NAVEUR) Surgeon’s headquarters in December. The conference brought together the senior medical advisors in the European theater (l-r: COL Mark Ediger, USAFE Surgeon General; COL Cornelius Maher, USAEUR Deputy Surgeon General; COL David Schall, EUCOM Surgeon General; CAPT Alton Stocks, CNE-Force Surgeon) to discuss issues such as, Avian Flu Influenza plans, medical support to Africa Command (AFRICOM), and updates on current EUCOM theater security plans. Photo by MC1(AW) Nathan L. Guimont, USN

Japanese Doctors Tour USS Essex

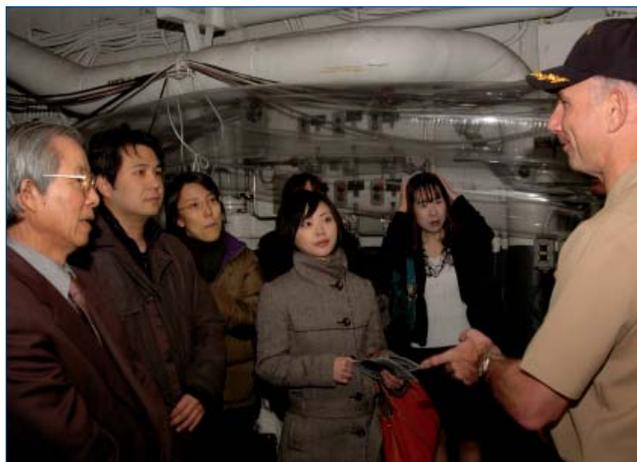
USS *Essex* (LHD-2) hosted 18 Japanese doctors from the Sasebo community 23 December to demonstrate the ship's medical capabilities as well as its ability to provide air and sea support used during disaster relief operations. According to LT Scott Margraf of the Sasebo Branch Medical Clinic, sharing knowledge and capabilities will give confidence to the doctors in Sasebo if a disaster were to hit Japan. *Essex* played a key role in disaster relief after a tsunami hit Indonesia in 2004.

"If there is ever a disaster in the Sasebo area, we would need to pool our resources. It's imperative to know ahead what medical capabilities each other has," said Margraf.

CDR Brett V. Sortor, *Essex* senior medical officer, also emphasized the importance of joint cooperation between the Navy and the Sasebo community. "We rely on Japanese healthcare to take care of patients in their hospitals," said Sortor.

While *Essex*'s primary mission is to conduct prompt and sustained combat operations at sea, its secondary mission is to serve as a hospital during humanitarian missions and disaster relief. *Essex* has more than 320 beds for patients, a 14-bed intensive care unit, and two operating rooms. "With all our capabilities, *Essex* is like a small community hospital. It's amazing when people see we have more capabilities than most hospitals of comparable size," said Sortor.

"The intensive care unit (ICU) and operating rooms were really interesting to me," said Sadahiro Asai, a Japanese pulmonologist at SoGo Hospital in Sasebo. "I really appreciate



SASEBO, Japan (December 2006) - CDR Brett V. Sortor, SMO for USS *Essex* (LHD-2), explains the medical facilities during a tour for doctors from local area hospitals. Sasebo, Japan. Photo by MC Michael A. Lantron, USN

and am thankful for the opportunity to come onboard and tour the ship."

The relationship between *Essex* and its surrounding community is a vital part of military operations. This visit aboard *Essex* was another step in the ongoing process of integrating U.S. Navy assets into the Sasebo community. "There is a Japanese word, *nemawashii*, which means 'root binding,'" said Margraf, describing the cultural process of gaining approval for decisions before the decision-makers complete the decision. "In order to work together, we must have visits like this where we learn *nemawashii*."

Essex is part of the flagship *Essex* Expeditionary Strike Group (ESXESG), operating out of Sasebo, Japan; which serves under Commander, Expeditionary Strike Group (ESG) 7/Task Force (CTF) 76, the Navy's only forward-deployed amphibious force. Task Force 76 is headquartered at White Beach Naval Facility, Okinawa, Japan, with an operating detachment in Sasebo, Japan. 

—Story by MC Michael Lantron, USS *Essex* Public Affairs, Sasebo, Japan.

Camp Pendleton Medical Battalion Provides Care to Military and Civilian Iraqis

Charlie Health Services Company Al Asad detachment, 1st Medical Battalion Camp Pendleton, CA, of Combat Logistics Regiment 15, has operated on more than 200 patients and completed more than 400 Level II resuscitations from August to December 2006 in support of Operation Iraqi Freedom.

According to CDR Richard Sharpe, detachment officer-in-charge, the company's mission is to provide Level II care, which is the first echelon of care that surgical resuscitation can be performed. "We take care of everyone that is brought to us, which includes US Armed Forces, Coalition forces, Iraqi Security Forces—mainly Iraqi Army and Iraqi Police—Iraqi civilian men, women and children, and detainees; whoever is brought to us, we treat," Sharpe said.

"The patients are from Level I facilities, which are battalion aid stations, shock trauma platoons, or directly from the battlefield to here," he added.

Like doctors, Navy nurses and corpsmen take a solemn pledge to treat all injured, regardless of nationality, treating all equally.

"It's not a struggle to treat everybody equally, but there is something there that you feel and see, knowing that if this detainee was awake right now he could try to hurt you, but you're trying to protect him," said LT Alecia Gende, an in-route care nurse. "You're risking your life and all the crew on



HM3 Aloen Delapena applies clean bandages to a wound on the face of an Iraqi citizen. Al Asad, Iraq. Photo by MC Kenneth R. Hendrix, USN

that helo to take this guy who is trying to kill us to the next level of care so we can prevent him from dying,” Gende said.

The corpsmen function a lot more independently here and for junior corpsmen like HM(FMF) René Acerosalazar who is grateful for the training he receives and the experience. “I didn’t like doing stitches at first because it’s intimidating with the patient looking at you and I would get nervous,” Acerosalazar said. “But the nurses and experienced corpsmen let me know the patient doesn’t feel anything and not to worry. It’s good to know they’re here for me.”

First-time deployed HM1(FMF) Brandi Collins, who has previously served as a histology technician and independent duty corpsman, shared one of her profound moments in the emergency trauma room. “We had a gentleman that we had to start cardiovascular pulmonary resuscitation (CPR) right as he got off the helo because he was crashing. It was the first time I performed CPR since graduating from school. I jumped on top of the gurney, started CPR, and rode in with him from the helo pad to operating room,” Collins said.

The battalion has a full-time interpreter on staff to help communicate with the Iraqi citizens. “The interactions we have with the Iraqi patients is very positive,” said Sharpe. “They appreciate the fact that we are here to take care of them, no matter who they are.”

—Story by MC Kenneth R. Hendrix, Navy Expeditionary Logistics Support Group Public Affairs, Al Asad, Iraq.

Navy’s Leadership “Dock” at TQ

The United States Navy’s top sailors visited Camp Taqaddum 23 December. ADM Michael G. Mullen, Chief of Naval Operations, and MCPO Joe R. Campa Jr., Master Chief Petty Officer of the Navy, visited to speak with sailors and Marines on base.

The visit was part of a tour through Al Anbar Province where Mullen and Campa met and greeted sailors fighting in support of Operation Iraqi Freedom, which according to the service members featured, was a morale booster. “It was a great experience to be able to meet the Chief of Naval Operations,” said HN Tiffany N. Reese, with Surgical and Shock Trauma Platoon, Taqaddum Surgical, 1st Marine Logistics Group (Forward). “Knowing the position that he holds, and that he still comes out and sees the troops, is very rewarding.”

During the visit, hospital personnel gave Mullen a tour of Taqaddum Surgical, where the leaders met sailors and Marines. While Mullen toured TQ Surgical, Campa met with the senior enlisted—chief petty officer and above—and requested the sailors to continue focusing their efforts on “deck-plate” leadership.

“Deck-plate” leadership, according to Campa, is a method for sailors to replace the idea of “command and control” with “commitment and cohesion.” After the meetings, Mullen and Campa shared lunch with several sailors and Marines, and listened to comments from the troops about their experiences in Iraq.

After lunch, an open-forum meeting was held at the main-side chapel to give opportunity for any sailor to ask the CNO or the MCPON what was on their mind. The leaders answered questions ranging from subjects like the increase of troops in Iraq to improving education for sailors on active duty and reserve.

“The focus is always on the Marines and sailors,” said Mullen. “I thank you for your service and I am grateful to be here and in uniform with you.”

Mullen and Campa told the sailors and Marines “not a day goes by where they don’t think about them.”

—Story by CPL Ryan L. Tomlinson, 1st Marine Logistics Group, Camp Taqaddum, Iraq.



ADM Michael G. Mullen watches doctors performing surgery at Taqaddum Surgical during a visit to Camp Taqaddum, Iraq. Photo by LCPL Ryan L. Tomlinson, USMC, 1st Marine Logistics Group



Philadelphia, PA. Sailors unload an injured passenger from the cruise liner *Celebrity Century* onto the multipurpose amphibious assault ship *USS Wasp* (LHD-1). Sailors from *Wasp* are transporting three civilians and one Chilean sailor in need of medical care to the nearest hospital. November 2006. Photo by MC1 Jeremy Siegrist, USN



Pacific Ocean. HM1 Anthony Naul cleans the teeth of a sailor aboard *USS John C. Stennis* (CVN-74). January 2007. Photo by MC John Wagner, USN



Yokosuka, Japan. LT Brian Rounds and HM Manouchka Eugene perform a routine cleaning at Fleet Dental at Yokosuka. January 2007. Photo by MC Kari R. Bergman, USN



Atlantic Ocean. Surgical technician, HM1 Queena Nash, left, passes a pair of hemostats to the ship's surgeon, CDR Stanley Napierkowski, during surgery to repair a sailor's inguinal hernia in the operating room on board *USS Harry S. Truman* (CVN-75). *Truman* is currently underway conducting flight deck certifications in the Atlantic Ocean. January 2007. Photo by MC3 Kristopher Wilson, USN



Sasebo, Japan. HM1 Joseph Calderon, assigned to Naval Branch Health Clinic Sasebo's emergency response team (ERT), goes through a decontamination shower after a mass casualty drill as part of Exercise Keen Edge at Fleet Activities Sasebo. Keen Edge is a joint and bilateral command post exercise designed to increase interoperability and readiness between U.S. and Japanese forces. February 2007. Photo by MC2 Ryan McGinley, USN



Al Asad, Iraq. LCDR Thomas Friedrich, assigned to the 1st Medical Battalion, Camp Pendleton, performs a medical evaluation on an Iraqi citizen. The 1st Medical Battalion provides level II care, which is surgical resuscitation to U.S. Armed Forces, coalition forces, Iraqi security forces, and civilians in support of the global war on terrorism. December 2006. Photo by MC Kenneth R. Hendrix, USN



Persian Gulf. HM2 Scott Grucza examines the hand of an injured sailor aboard amphibious assault ship USS *Boxer* (LHD-4). *Boxer* is currently conducting Maritime Security Operations (MSO) in support of 5th Fleet. January 2007. Photo by MC Joshua Martin, USN



Camp Taqaddum, Iraq. LT Ron F. Sanders, NC, with Taqaddum Surgical's Forward Resuscitative Surgical System, evaluates an incoming 'patient' during a mass casualty drill. January 2007. Photo by LCPL Geoffrey P. Ingersoll, USMC



Naval Hospital Bremerton. Stairchair: Staff members at Naval Hospital Bremerton carry one of their own on the hospital's new stair chairs during emergency patient evacuation training. Emergency evacuation was just one aspect of the hospital's earthquake preparedness training drill. Photo by MC1(SW) Fletcher Gibson, USN



Sasebo, Japan. HMCS Michael Bowe-Rahming prepares for a training dive aboard the rescue and salvage ship USS *Safeguard* (ARS-50) during at-anchor dive operations off the coast of its forward-deployed home of Sasebo, Japan. January 2007. Photo by MC Kyle Carlstrom, USN

Doctors, Corpsmen Practice Hand-to-hand Combat

When they're not combating patients' injuries, a few doctors and corpsmen at Taqaddum Surgical are learning hand-to-hand combat, Marine Corps style.

Sailors recently attended Marine Corps Martial Arts Program (MCMAP) classes a few hours every day for approximately 2 weeks. And though they all walked a little taller wearing their Marine Corps tan belts, for some of the sailors, their new sense of pride wasn't only located around their waists.

"MCMAP has an effect that transcends well beyond the physical activity," said CAPT Michael A. Thompson, officer-in-charge of TQ Surgical, 1st Marine Logistics Group (Forward). "It's a team building exercise," continued Thompson. "It teaches leadership, cohesiveness, and unit integrity. And, plus, it's fun."

"How often do you get to put your boss in a headlock," said LCDR Pamela C. Harvey, MC. Harvey laughed after recollecting some MCMAP methods she had to practice on Thompson.

Service members often paired up to practice their MCMAP regardless of rank. To the instructor, this type of bond is just another benefit of the program.

"It builds up their camaraderie," said GSGT Eric E. Harris. "It helps service members get to know each other better, beyond rank and work. They see a totally different side of a person," said Harris, a MCMAP black belt instructor.

"The people who took the class feel like they've accomplished something together," pointed out HM1 Allan D. Felicano. "It's a good way to gain more confidence by challenging one's fortitude and endurance."

According to a few sailors, the class pushed them to their physical limits. Some said they wouldn't have made it without motivation from each other and from Harris. "He's got a tremendous attitude," said Thompson of Harris, "He really fulfilled and exceeded my expectations, and he integrated the technical aspects of martial arts training but really infused aspects of the team mentality."

Thompson recalled a time during the class when the students were performing a conditioning exercise. He said he had been wondering if he was capable of finishing the exercise, when Harris leaned over him and said, "You think you're tired, look at the guy next to you." Thompson saw that the student beside him, a corpsman, was tired, but he was not giving up.

"Other team members were inspiring," said Felicano, "It got certain members through. We started together, and we finished together."

"They learned never to leave anyone behind, never quit trying, and support each other," said Harris.

Besides a new sense of confidence and teamwork, the students also gained an improved ability to defend themselves. This may prove to be a useful skill for corpsmen working closely with Marines. "When we go off base, we're not going to have rifles," said Felicano. He said that if something goes wrong, he feels "a little more prepared to protect patients."

If attacked, "I don't want to feel like I am a drag on the Marines with us," said Harvey.

Wearing a MCMAP belt as a corpsman also gains Marines' attention, said Thompson. "It really earns us some credibility," Thompson continued. "The Marines do not give out their acceptance lightly."

Thompson also emphasized the necessity for his sailors to learn as much about Marine culture as possible. And where better to start, then with Marine Corps Martial Arts. "MCMAP gives us insight into the Marine Corps mission, and from a medical standpoint, there is no greater honor than to be attached to a Marine Corps unit," said Thompson. 

—Story by LCPL Geoffrey P. Ingersoll, 1st Marine Logistics Group, Camp Taqaddum, Iraq.



HN Lyndon S. Jagroop, a field medical technician with Taqaddum Surgical, 1st Marine Logistics Group (Forward), practices a Marine Corps Martial Arts leg sweep. When they're not combating patients' injuries, a few doctors and corpsmen at TQ Surgical are learning hand-to-hand combat, Marine Corps style. Photo by LCPL Geoffrey P. Ingersoll, USMC

Iraq's Future Stands up with Help from Supplies

They called, and we answered. American forces and Iraqi soldiers reached out in response to local civilians' requests for medical care and school supplies during a humanitarian mission. "The civil affairs piece [of our mission in Iraq] is how we build a relationship and build trust in their community, and also how we help the Iraqi Army and the Iraqi infrastructure stand up on their own," said CAPT Adam A. Gilbertson, USA.

The Iraqi Army led service members from door to door in the town of Mular, interacting with locals and offering aid in any way possible. Civilians who seemed initially apprehensive soon became friendly, offering gratitude and sometimes tea to their visitors.

"With somebody carrying a rifle, [who] speaks their language, walking up to them, and asking them questions, [the civilians] were kind of stand-offish," said 1st LT Sean M. Kiesz, USA, platoon leader for Able Company, 2nd Combined Arms Battalion of the 136th Infantry Regiment, attached to 1st Marine Logistics Group (Forward).

"But as time went by they got a reassuring feeling and they opened up," continued Kiesz.

"This is the first time the Iraqi Army appeared in Mular since 2003 when they were under Saddam's leadership," said Gilbertson. Gilbertson said that this time the Iraqi Army's approach was probably different. "The Iraqi Army brought an ambulance so that we were able to bring people to the clinic right from their homes," said Gilbertson.

In a united effort, American and Iraqi forces set up a temporary medical-care clinic adjacent to the town's public school. Simultaneously, Iraqi soldiers and American service members traveled door to door, stopping to inform citizens of the clinic as well as talk about any concerns local citizens might have had.

"This mission gives citizens in the area exposure to the military with something other than a combat military operation," said LTCOL Joseph T. Burns. Citizens talked openly with the Iraqi Army once they learned the purpose of mission. At one home, an Iraqi interpreter proclaimed with a smile "Don't worry, the good guys are here!" An Iraqi man and his wife chuckled at the interpreter, and Iraqi soldiers scooped up their smiling children.

"It's a goodwill builder, which is certainly important in what we're doing here," said Burns.

Along with medical attention, service members presented the school with many boxes filled with pens, pencils, papers, dolls, and soccer balls. Lined up in eager anticipation, the children walked away with armfuls of supplies handed to them directly by Iraqi soldiers.



American forces and Iraqi soldiers reached out in response to local civilians' requests for medical care and school supplies during a humanitarian mission. Photo by LCPL Geoffrey P. Ingersoll, USMC

"It's very important to get the Iraqi Army involved," said SSGT Brian M. Ness. It shows the people that their soldiers are part of their eventual independence, added Ness. Kiesz agreed and emphasized the importance of Iraqi children to international relations. "If we can build trust in an Iraqi kid, then when he grows up and becomes a soldier or a town leader, that relationship will still be there," said Kiesz.

The future was on the minds of many Americans and Iraqis during the mission. And in the eyes of some service members, rebuilding Iraq's educational system is as important as rebuilding their army.

"When we educate the kids, it's better for them because in the long run they are going to be the leaders of this country," said HM3 Kyle B. Whiteman. "The more educated they are, the better the country will become," continued Whiteman.

Iraqi school officials also received a \$500 check from Iraqi Army General Behe'a Hussein Abed Hassen on behalf of 2-136. But for a few service members, no price tag could be attached to the support and improved morale supplied by American and Iraqi forces. "No matter what it is—security, medical, or just someone to talk to—they know that we're here for that . . . they can definitely move forward from this point on," said HM1 Amber N. Floyd.

"This mission achieved the idea that the Iraqi Army is a valuable part to freedom for this country," said Ness, "they showed that they can make a difference in their own community." 

—Story by LCPL Geoffrey P. Ingersoll, 1st Marine Logistics Group, Camp Taqaddum, Iraq.

Navy Physician Named Recipient of William Kane Rising Star Award For 2007

A preventive medicine physician from Navy Environmental Health Center, currently deployed as the deputy medical adviser for the NATO International Security Transition Force (ISAF), was honored 24 February for winning the 2007 American College of Preventive Medicine (ACPM) William Kane Rising Star Award.

CDR Paul D. Rockswold, MC, (UMO), is being recognized for his many contributions, including his role as the deputy command surgeon, Combined Forces Command – Afghanistan, and deputy medical adviser, working with the highest levels of the Afghan government to help build the medical infrastructure of the country and its security forces, including his participation in efforts to eradicate polio on a global level.

The award presentation is scheduled to be held at the ACPM Awards Banquet in Miami.

This highly prestigious award recognizes physicians on a national scale for significant contributions in preventive medicine. According to Rockswold, this is a crowning achievement in his profession.

Rockswold is also renowned for his work as a physician epidemiologist where he played a key role in the development of the Navy Environmental Health Center's Epidemiology Data Center, a

state-of-the-art surveillance system for tracking and analyzing injury and disease Navy and Marine Corps wide.

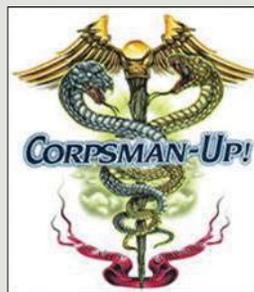
He has also been involved in the investigation of epidemiologic concerns such as Dengue Fever, Plague, Tuberculosis, Norovirus, and Guillain-Barré Syndrome.

"The time in Afghanistan has been a tremendous opportunity to provide meaningful input toward the stabilization of a country," said Rockswold. "My perspective has grown greatly. I believe that peace and stability will improve the health and safety for Afghans." 

—Story by Hugh Cox, Navy Environmental Health Center Public Affairs, Portsmouth, VA.



CDR Rockswold with Afghan children. Photo courtesy of CDR Rockswold



HM Matthew G. Conte, 22, of Mogador, OH, died 1 February from injuries suffered while his unit was conducting combat operation against enemy forces in Al Anbar Province, Iraq. Conte was assigned to 2nd Battalion, 3rd Marine Regiment, 3rd Marine Division, III Marine Expeditionary Force, Kaneohe Bay, HI, serving in Iraq under the command of I Marine Expeditionary Force (forward).



HM Kyle A. Nolen, 21, of Ennis, TX, died 21 December from injuries suffered as a result of enemy action in Al Anbar Province. Nolen was assigned to 3rd Battalion, 4th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Twentynine Palms, CA



LCDR Jane E. Lanham, MSC, 43, of Owensboro, KY, died 19 September 2006 of natural causes. Lanham was assigned to the Naval Branch Health Clinic, Bahrain.

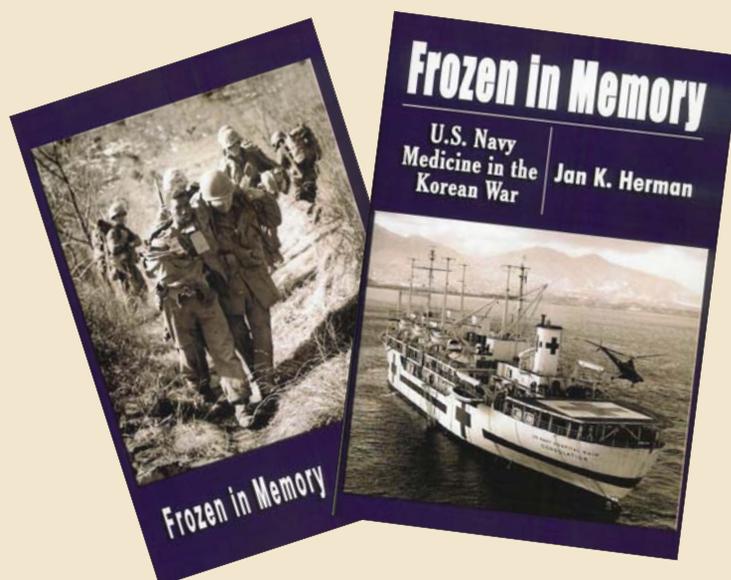
Korean War Medical Personnel and Patients Tell Their Stories

For better or worse, Americans have defined military medicine during the Korean War by a novel, a movie, and a long-running TV show. But was the Korean War really like M*A*S*H? This was the war characterized by innovation—helicopters swiftly airlifting wounded patients from the battlefield to medical care, the first large-scale use of antibiotics during wartime, and the pioneering practice of vascular surgery that saved many a limb from amputation.

In a new book, *Frozen in Memory: U.S. Navy Medicine in the Korean War* by Navy Medical Department Historian, Jan Herman, both Navy medical personnel and their patients recount their “forgotten war,” the dirty little conflict that somehow has fallen through history’s cracks since it was fought more than 50 years ago. Neophyte physician Henry Litvin describes how he practiced medicine during the Chosin Reservoir campaign while trying to survive 30-below-zero temperatures and a ferocious enemy bent on annihilating him and his comrades. Hermes Grillo, a Harvard Medical School graduate, recalls how he ended up a few miles from the front operating on scores of mangled young men—without the benefit of x-ray equipment—and forced to use retractors made from the brass of discarded artillery shells. Physician Clifford Roosa remembers the day an accidental explosion aboard his ship snuffed out the lives of 30 men in an instant. The legendary Dr. Joel Boone, World War I Medal of Honor recipient, tells how he came up with the idea of equipping hospital ships with helicopter landing decks. And Pearce Grove, once a machinist’s mate aboard USS *Consolation*, gives an account of the historic first-ever landing of a patient-carrying helicopter aboard one of those gleaming white ships. Sarah Griffin Chapman, a former Navy nurse who lost a leg in an accident before Korea, reveals how she fought to be recalled to active duty so she could teach young amputees like herself to walk again. Sergeant John Fenwick, a Marine who had nearly been torn to pieces by a North Korean machine gunner, details his rescue by a Navy corpsman and the long road to recovery from his wounds. That corpsman, Glen Snowden, relates the same story from his own perspective. Was the Korean War really like M*A*S*H? In *Frozen in Memory*, the caregivers and patients answer that question.

Frozen in Memory is Herman’s second book of a planned trilogy. *Battle Station Sick Bay: Navy Medicine in World War II* was published in 1997. *Into the Dragon’s Mouth: Navy Medicine and Vietnam* is due out in 2008.

Frozen in Memory is available through Booklocker (<http://www.booklocker.com>).



Juel Loughney

Navy Nurse, Teacher, Mentor, and Friend

CDR Patricia Rushton, NC, USNR (Ret.)

CAPT Juel Loughney, NC, USN, has witnessed the progress of Navy medicine for over 40 years. Her experiences prepared her to support, encourage, and advocate for patients, colleagues, and friends. Her story reflects the experiences of many nurses who have served in the Navy Nurse Corps.

Caring Servant

Juel Loughney graduated from Pittston Hospital School of Nursing in Pittston, PA, in 1956. While working as staff at the hospital she enrolled at College Misericordia in Dallas, PA, in an RN BSN completion program. After receiving her degree, she was asked to teach at the Pittston Hospital School of Nursing and remained on the faculty teaching medical surgical nursing for 7 years.

CAPT Loughney's desire had always been to be a Navy nurse. However, she waited 10 years after graduation to join the Navy. With both parents dead, and being the oldest of eight, she felt she first had to raise her four younger brothers.

Juel was sworn in as a lieutenant in October 1966. This began a long career filled with service to others. "This had been my desire for years," she later related. "At age 31, I went into the Navy. One of the greatest highlights of my life, besides becoming a nurse, was joining the Navy."

CAPT Loughney's first duty station was Naval Hospital Annapolis, a significant assignment for a nurse brand-new to the Navy. She used the experience to learn about the Navy, the Navy medical system, and, perhaps, unconsciously, some of the nuances and subtleties of Navy organizational structure. These were skills that would help her advocate for patients and colleagues later in her career.

"One of my responsibilities," she recalls, "was detailing corpsmen to Vietnam. It was heartbreaking because the turnover of corpsmen was so fast and furious. You got these young people right from corps school who hardly knew their way around, and in 2 months I was sending them to Vietnam. That was very hard for me. I'm sure people today feel the same way."

In 1968, then LT Loughney received orders for Vietnam. As with so many other military nurses, she asked to go to the area of armed conflict. The request was made from a desire to serve sailors and Marines at the battle front.

Assigned to USS *Sanctuary* (AH-17), a hospital ship stationed off the coast of Vietnam, she now recalls caring for many patients with malaria, of how ill they were with high fevers, and how some died before they could be successfully treated. She remembers having to make critical decisions about the use of resources in order to treat those patients. She talks about caring for the many patients with multiple injuries, specifically those with single or multiple amputations. One specific patient stands out. "Every time we thought we would get him stable enough to have him medevaced back to Japan, he would start bleeding again. You just knew he was never going to make it. Every time I go to the Vietnam Wall, I look up his name. He is one that will always remain in my heart."

LT Loughney spent a year on *Sanctuary* and returned home. She subsequently served at Naval Hospital San Diego; Hospital Corps School San Diego; Naval Hospital Subic Bay, Philippines; Fresno State University; Naval Hospital Long Beach; Naval Hospital Great Lakes; and the Bureau of Medicine and Surgery (BUMED) as the Navy Nurse Corps Career Plans. She was then assigned as Director, Nursing Services at the National Naval Medical Center Bethesda.

In her long career, she went from staff nurse to supervisor to assistant chief nurse and director of nursing service. Juel notes how her experience at BUMED prepared her for the new position at Bethesda. "There were many positive aspects being at BUMED that were very helpful to me. For 2 years I was fascinated with politics. It prepared me well when I went to Bethesda."

CAPT Loughney was deeply concerned about the responsibility involved in taking on this assignment of director of nursing service. She was responsible for the deployment of nursing service personnel on USNS *Comfort* (T AH-20) and was Director of Nursing Service as the ship served in the Persian Gulf during Operation Desert Shield and Desert Storm.



She completed her 29-year active duty career as the Executive Officer and Acting Commanding Officer of the Clinics Command, Newport, RI.

Patient Mentor

Juel Loughney has been a mentor and advocate for colleagues and Navy nursing since the beginning of her naval career. As a junior nurse aboard *Sanctuary*, she assisted other nurses and corpsmen to deal with the devastation of that war. To a nurse colleague who said, “When we leave this office, I leave my sense of humor behind.” Juel responded, “Once you get out there that’s when you really need a sense of humor.”

After her experience in Vietnam and her assignment to corps school in San Diego, she recalls that, “We were still getting the Vietnam casualties back. Corps school was an eye-opener for me. I had taught for many years, but had a great appreciation for corpsmen at that point. I had the experience then to tell them what they needed to know and learn while they were in corps school.”

When *Comfort* was deployed for Desert Storm, CAPT Loughney was responsible for over 700 people. Her job was to prepare the ship and the nursing staff to function effectively and efficiently to provide the best possible care. She also had to support the staff emotionally in a time of crisis. “I had meetings with the nurses once a week, and every other week with the corpsmen. I would talk about what was going to happen and what we were going to do. It was a good time for them to vent. It was very helpful. They would say, ‘CAPT what’s going to happen if we hit a mine?’

“I said, ‘You know the Persian Gulf is very shallow. If we hit a mine we are not going to sink very far.’

“I can remember the day we were heading up north to Kuwait. I walked outside my office and a line of corpsmen confronted me—all these young faces with their eyes looking up as if to ask, ‘What’s going to happen?’ I don’t know what I said to them. When I had talked to the nurses, of course, we laid things out. I talked to them as plain as I could.”

Fellow nurse Susan Jackson notes that when Juel returned from Desert Shield and Storm as Director of Nursing Service at NNMC Bethesda, she opened up the Navy Nurse Corps birthday party to all “my nurses”—military, civil service, and contract. She made everyone feel special and part of the Bethesda team.

Juel Loughney is also friend and mentor to CAPT Elizabeth Barker. Barker recalls how her friend taught her how to handle the politics of command. “Juel knew how to learn the political situation, how to learn to read it so that you didn’t become a political animal. You just became smart. It’s about keeping your integrity and your soul as a nurse, but not being stupid about the political situation, so you don’t set yourself up to be a victim. Juel was very smart about that.”

Loyal Friend

Juel Loughney has made so many friends and has been a friend to so many throughout her Navy career. She remem-

bers the names and relationships with the people who influenced her life. She continues to cultivate those friendships. She recalls one dear friend she made in Vietnam.

“She had been in Danang and could never make herself go to the Vietnam Wall. We finally talked her into joining us in the parade to the Vietnam Women’s Memorial. We made sure she was comfortable. During the time we walked down Constitution Avenue, some people asked us, ‘Were you on *Sanctuary*?’ One patient kept asking, ‘Were you in Danang?’

“Somebody said, ‘I know a nurse who was in Danang.’

“Then to my friend the nurses said, ‘There’s a patient over there. You probably don’t know him and you probably never took care of him, but he wants to meet a nurse who was in Danang Hospital when he was there.’

“We took my friend to meet him, and she ended up spending the whole day with him and his family. I think that made the biggest difference in the world for her. She didn’t have the same fear after that. It was the dread we all had of looking at that wall and knowing that you took care of many of the men listed there. I think it was very healthy for her that day. I think she has gone back a couple of times since then.”

Juel Loughney is herself now struggling with illness. She has handled the affliction with the same dignity and positive attitude as with every other crisis she has had to face. Navy nurses, friends, and family have been constantly at her side—caring, supporting, and encouraging. Friends from around the world have supported her through letters, emails, care giving, and visits. One physician said to Juel, “With all the service you have given to others during your lifetime, you have been given special grace to deal with this disease now.” Juel would like to express her deep appreciation for this constant support, which exemplifies Navy nurses, wherever they may be. She would also like to share that she and her doctors are striving toward and are expecting a complete recovery.



CAPT Juel Loughney is the finest example of what nursing should be. Her willingness to share her knowledge and experiences with associates, colleagues, friends, and family has made us all better at whatever we do. We hope that all who have benefitted by knowing Juel Loughney will continue that legacy by caring, mentoring, and befriending others. 

This account is part of the Nurses at War Project, an ongoing program at Brigham Young University College of Nursing. The project collects the accounts of nurses who have served during periods of armed conflict. If you are a nurse or know a nurse who has served in wartime, and would like more information on how to participate, please contact CDR Patricia Rushton, NC, USN (Ret.), RN, Ph.D., at Patricia_Rushton@byu.edu

Hidden in Plain View

CAPT Patricia M. Collins, NC, USNR (Ret.)

No one ever sat down and designed the U.S. health-care “system.” It simply evolved in bits and pieces. As it now threatens to crack under its own weight, a Dartmouth Medical School faculty member is a leading proponent of the need to stop tinkering and rethink things—from a “microsystem” perspective.”(1)

“Clinical microsystems are the front-line units that provide most health care to most people. They are the places where patients, families and care teams meet. Microsystems also include support staff, processes, technology and recurring patterns of information, behavior and results. Central to every clinical microsystem is the *patient*.”(2)

“The microsystem is the place where:

- Care is made (1)
- Quality, safety, reliability, efficiency, and innovation are made (2)
- Staff morale and patient satisfaction are made (3).

Microsystems are the building blocks that form hospitals. The quality of hospital care can be no better than the quality produced by the small systems that come together to provide care. The hospital quality equation can be expressed as hospital quality = quality of microsystem (1) and the quality of microsystem (2) and the quality of microsystem.(3)

Finding time to improve care can be difficult, but the only way to improve and maintain quality, safety, efficiency, and flexibility is by blending analysis, change, measuring, and redesigning into the regular patterns and the daily habits of front-line clinicians and staff. Absent the intelligent and dedicated improvement work by all staff in all units, the quality, efficiency, and pride in work will neither be made nor sustained.(3)

Contemporary patient quality and safety literature are highlighted by the idealized design concepts generated by the Clinical Microsystems work of Dartmouth College and the Institute for Healthcare Improvement. Meanwhile, the chronic care model developed by the MacColl Institute for Healthcare Improvement Innovation at the Center for Health Studies, Group Health Cooperative is considered a template for replication across the country due to its success in physician and patient satisfaction and positive clinical outcomes. This institute was derived from Ed Wagner’s Improving Chronic Illness Care model.

Wagner’s chronic care model identifies the “essential elements of a healthcare system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Evidence based change concepts “within each element “foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings, and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings”. “The current five themes incorporated into the Chronic Care Model are:

- Patient safety (in the Health System)
- Cultural competency (in Delivery System Design)
- Care Coordination (in Health System and Clinical Information Systems)
- Community policies (in Community Resources and Policies); and,

•Case Management (in Delivery System Design)”(4)

Another leader in innovative health care delivery is the Institute for Family-Centered Care (IFCC). The IFCC describes its core concepts of patient and family-centered care as:

“Dignity and Respect. Providers listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

Information Sharing. Providers communicate and share complete and unbiased information with patients and families that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to participate effectively in care and decision-making.

Participation. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

Collaboration. Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health

care facility design; and in professional education, as well as in the delivery of care” (5)

A unique feature of the IFCC is their concept of the role of patients and family advisors to clinic or hospital staff on committees and various programs to operationalize patient-partnerships. These patient or family advisors have the potential to reflect a range of experiences within the unit, hospital or clinic they serve and can provide valuable insights into process improvements.

Within the Military Health System is a shining example of a clinical microsystem and exemplary utilization of the Chronic Care Illness Model, the Clinical Microsystem, and Patient-and Family-Centered Care. The WRAMC Clinical Breast Care Project (CBCP) has executed the above concepts through their management of care as described by COL Craig Shriver, Director of the CBCP. (6) When a patient is first told that she has breast cancer, she is conceptually unable to “hear” anything else at that time, due to the immediate emotional impact of such a feared diagnosis. Therefore, all newly diagnosed patients are seen on Friday of that week, so that they can have a comprehensive multidisciplinary workup and be accompanied by either their spouse or significant other. When the patient arrives, she is escorted to a tastefully decorated exam room that is spacious enough for her spouse to be seated. A portable screen is used for privacy during physical examinations. Rather than require the patient to travel to all the specialists for consultation on different days [surgeon, radiation oncologist, medical oncologist, psychologist, nutritionist, etc.], all the specialists see the patient in the same examination room, in one morning, on a rotating schedule. If a procedure is required, e.g., tissue biopsy, it is performed in an adjacent room equipped with a high definition screen on the ceiling so that the patient may view a DVD of her choice during the procedure.

Following the complete workup, the patient and her spouse have lunch, as does the staff. Then, all the specialists convene in a conference and along with the Radiologist and Pathologist to review films and biopsies, review all their findings as a group. The patient and spouse may choose whether or not to attend this discussion. Following the discussion of the specialists, they meet with the patient and spouse and present the options specific to her. This method of physician communication and consensus avoids conflictual messages to the patient and allows for the best evidence-based approach. The literature supports

the notion that a group decision is superior to sequential individual ones.

Additional features of this approach are that the décor of the unit was designed by a patient council. To a person, none of them wanted a pink color theme in their breast center! Instead they chose a rich merlot color and contemporary furniture. They also elected to have a waterfall on one of the walls in the waiting room. The restrooms and examination rooms have attractive mirrors and potpourri. Patients who had previously experienced breast cancer care prior to the CBCP, which opened in 2001 at WRAMC, are overjoyed at the patient-centered approach. Another important feature is that the clinic follows these women for life, which supports their clinical and emotional needs.

The staff turnover is low, which enhances continuity of the program philosophy, communication, patient safety, and partnering with the patient and her family. As Chief of General Surgery, Surgical Residency Program Director, and Director of the CBCP, COL Shriver has faced the challenges of the volume of relative value units (RVUs) generated since only about five patients are seen on the Friday comprehensive cancer clinics. But then as Einstein said, not everything that counts can be counted. Certainly the staff and patient satisfaction, stability of staff retention, partnership with the patient and her family, and continuous improvement attitude, creates optimal outcomes in a safe, high quality, and supportive, attractive physical environment. As Residency Director, clearly COL Shriver leads by example and has an impact on physicians during their graduate medical education by experiencing how idealized care can be operationalized in a military setting. This model of care should certainly be considered as the National Capital Area moves forward with the merger of Walter Reed Army Medical Center with the National Naval Medical Center and becomes the Walter Reed National Military Medical Center (WRNMMC) in 2011.

References

1. <http://www.clinicalmicrosystem.org/content.htm>.
2. <http://cms.dartmouth.edu/greenBook.htm>
3. Ibid.
4. <http://www.improvingchroniccare.org/change/model/components.html>
5. <http://www.instituteforfamilycenteredcare.org>
6. Personal communication with COL Shriver 

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Corpsman Down

***H**M3 Bob Ingraham served with 3rd Battalion, 1st Marines, in Quang Ngai Province, South Vietnam. On 5 March 1966, the second day of Operation Utah, his platoon engaged elements of the 21st Regiment of the Peoples' Vietnam Army, commonly but erroneously known as the NVA—North Vietnam Army. Operation Utah was the first major engagement between the Marines and regular North Vietnamese troops. Ingraham was seriously wounded in the ensuing battle for a hillock named "Hill 50."*

To the Marines of 3rd Platoon of Lima Company, 3/1, the sunny, warm morning of 5 March 1966 hardly seemed dangerous. Just ahead of us Marine Phantom jets were dropping napalm into what appeared to be an empty field. But throughout much of the night, the entire area had been subjected to heavy bombing and an artillery barrage which no one, it seemed, particularly the enemy, could have survived. In short, there appeared to be no direct threat to the platoon at that time.

Our anxiety levels increased when we started receiving fire from a nearby hill—"Hill 50," whose name I would learn many years later. The Marines responded with a few shots. But then word was passed to cease fire—South Vietnamese troops had fired on us by mistake. We relaxed and moved up the hill. No one on our side, apparently, knew that Hill 50 was a maze of tunnels and spider traps. Nor did they know that we were walking, oblivious, into a trap set by heavily armed North Vietnamese soldiers.

The assault on 3rd Platoon was sudden and furious. Second LT [Eugene] Cleaver, our platoon leader, was hit by a heavy-caliber shell that almost blew his right arm off at the shoulder. A rifleman had the top of his head blown off by a rifle or machine gun bullet. A 3rd Platoon sergeant sustained a pumping chest wound. Enemy soldiers we couldn't even see tossed grenades over the high, dense brush that surrounded us; a Marine hugging the ground next to me during a grenade attack was put out of action by a piece of shrapnel that pierced his buttocks.

After doing what little I could for LT Cleaver and the sergeant, I was told that a wounded Marine was farther up the hill. I soon found him. His abdomen had been blown open and his intestines were spilling out onto the ground. Amazingly, he was still conscious and seemed relatively calm. I was just beginning to consider what I could do to help him when a Marine further down the hill yelled, "I'm gonna throw a grenade over you guys! I'm gonna get that

sniper!" I didn't want to be killed by a Marine grenade, but as I started to hit the dirt I heard a loud gunshot to my right. In the same instant I was slammed to the ground by a bullet.

The bullet hit me on the right side of my right leg about 6 inches above the knee. It shattered the femur and blasted out through my inner thigh. It was like a really big sledge hammer had hit me. I don't remember falling; I was just instantly knocked flat. I knew I had been shot. I noticed that my foot seemed to be on backwards. Then I shouted: "Ski, the bastard shot me!" Ski, another corpsman, had been nearby when I was shot.

I had enough strength to lower my fatigue pants to examine the wound. The bullet had left a blue-rimmed hole on my outer thigh. It was about a third of an inch in diameter, roughly the diameter of a 7.62mm M14 or AK-47 round, and was hardly bleeding. (One North Vietnamese soldier who was killed that morning had been using an M14.) On my inner thigh was a patch of mangled flesh a few inches in diameter where the bullet, or what was left of it, had exited my thigh. It looked like fresh hamburger. Just a trickle of blood oozed from it; my femoral artery had apparently escaped damage. I could wiggle my toes: I had no major nerve damage.

In case I started bleeding heavily, I removed my belt and put it around my thigh to use as a tourniquet, but I was quickly losing strength and couldn't tighten it. Fortunately, I didn't need a tourniquet.

I tried to give myself some morphine, which we corpsmen carried in our Unit 1 medical bags, but I was so rattled that I forgot to puncture the seal of the foil syrette. When I tried to inject myself, the tube burst in my hand. It was the only syrette I had.

The battle was still going full blast. Nearby, a hidden rifleman continued to shoot, and I assumed he was the one who had shot me. I could hear him operating his rifle

bolt. Rockets and grenades were exploding and the sound of rifle and machine gun fire was constant. It seemed that every time an enemy rifle fired, a Marine screamed. I began to fear a “human wave” attack, so I took out my .45 pistol and held it on my chest, determined to kill the first Vietnamese I saw.

Eventually, a Marine crawled up the hill to try to help us: he was shot through the shoulder. So now there were three of us lying there. The Marine with the open abdominal wound kept asking me if he was going to die. I tried to reassure him, but I don't know to this day whether he lived. Another Marine crawled up the hill to help us and was also shot.

It wasn't long before I was almost completely incapacitated, not so much by pain but by extreme discomfort, for want of a better word. The sun was high overhead and intense. My thighs were getting seriously sunburned. (I had not been able to pull my pants back up after lowering them to see my wound.) I was sweating profusely. My skin became ultra-sensitive to touch. Even small bits of debris falling out of the sky from explosions resulted in pain. My entire body began to vibrate. It was as if every cell in my being was charged with electricity. It's hard to describe, but maybe there aren't any words for what I was feeling. Soon I began getting painful cramps in the muscles of not only my wounded leg, but my good leg as well.

A corpsman eventually reached us and managed to put a battle dressing on me. The shooting had slowed by then. Finally, I was half-carried, half-dragged down the hill on my poncho. I screamed every time my butt hit a bump. I don't think I'd been given any morphine. With every bump, I could feel the shattered ends of my femur grating inside my thigh. I feared they would cause more bleeding.

At the base of Hill 50, helicopters were starting to arrive to evacuate the wounded. I talked with the Marines. One Marine was crying. His best friend had just been killed before his eyes. I asked someone to take a picture of me, and I took one of him. The picture of me shows me holding my helmet tight to my head. I recall being afraid as bullets were still flying.

Eventually I was flown to a nearby field hospital. The corpsmen bandaged my wound more thoroughly, immobilized my leg in a splint, and packed me off to the hospital ship USS *Repose* (AH-16).

I don't remember arriving on the *Repose*, but recall lying on a gurney in a dark passageway for what seemed an endless period. It must have been late afternoon or early evening when surgeons finally operated on me. My femur was badly fractured. An x-ray shows shattered pieces of bone and frag-

ments of the bullet lodged in my muscles. The exit wound on my inner thigh told just part of the story. The muscle for several inches around the exit wound--and all the way down to the femur--had been turned to pulp by the bullet and had to be excised. Skin and some muscle around the entrance wound had to be trimmed away as well. I received two units of whole blood during the surgery.

When I left the OR, I had some new hardware--a threaded steel rod that went completely through my right shin about 6 inches below my knee. Later, it would be used as an anchor point for traction, which would stretch my thigh muscles and hold my femur at its original length while it healed.

Following surgery, the wounds were packed with cotton and thoroughly wrapped with bandaging. Next I was encased in plaster from my right foot all the way up to my armpits and down to my left shin. I was ready to be shipped home like a parcel.

I don't recall much about my short time on the *Repose*. I probably was getting morphine or Demerol regularly; I don't remember being in pain and I slept a great deal. I was probably also on antibiotics at this time. Any gunshot wound is a dirty wound by definition and subject to infection.

A bar hung from a frame over my bed that I could chin myself on, but its main purpose was to make it easier for me to use a bedpan. However, it also allowed me to raise myself higher so I could see the ocean through a nearby porthole. The *Repose* steamed constantly in big circles, or so it seemed to me, but I have been told by a former *Repose* crewman that the ship sailed back and forth between Chu Lai and Da Nang.



HM3 Ingraham lies seriously wounded as the battle continues around him.

Photo courtesy Robert Ingraham

I wrote a letter to my parents a day or two after the surgery. In handwriting even worse than my normal bad scrawl, I described the battle, explained how I was shot, and told them that my recovery would be long. I did not mention that I might lose my leg. I'm not sure that I myself was aware of just how serious my wound was.

After 2 or perhaps 3 days on the *Repose*, I was flown to Danang. The next morning personnel bundled me on board a C-130 Hercules, which flew to Clark Air Force Base Hospital in the Philippines where I would stay overnight. I was able to talk to my parents from the hospital via a telephone-ham radio link. Until that call, they did not know I had been wounded.

The next morning I was taken out to the airfield and put on a huge C-141 Starlifter. I recall little about that flight, but remember being in a huge, dark, noisy cavern filled with stretchers. Nurses and medics ran back and forth constantly. I had little pain but infections were raging in my wound and in my bladder. The bladder infection apparently came from poor procedure when I was catheterized on the *Repose*. I assumed that most of the wounded on the Starlifter were Marines from Operation Utah, but not until years later would I learn just how bad the casualties were. Historical records are not in full agreement, but it is clear that at least 94 Marines were killed and some 278 were wounded.

According to the 3rd Battalion's "Combat Operation After Action Report" dated 11 March 1966, 42 Marines were killed and at least 100 were wounded. Ten Lima Company Marines had been killed and 20 wounded, including myself.

The aircraft landed in Hawaii and an officer came on board to hand out Purple Hearts. My next memory is being at the hospital at Travis Air Force Base near San Francisco. A day later I had arrived back at the Naval Hospital at Balboa Park in San Diego where I had had my Hospital Corps training. I have fleeting memories of my arrival. I do remember very clearly, however, when corpsmen at Balboa removed my cast and the dressing from my wound. The blood-soaked cotton was firmly stuck to the wound. When the cotton was removed, it felt like flesh was being torn away. As soon as the cast came off, I was put into traction where I would be for the next 111 days.

My infections slowly yielded to antibiotics, and skin grafts helped to prevent the formation of excessive scar tissue—but scarcely improved the appearance of my leg!

Early in the summer I received another cast that kept my right leg immobilized but at least allowed me to hobble about on crutches. I also got my first liberty and had my first date with my fiancée, Susan Overturf, who had started writing to me when the 3rd Battalion was training in Okinawa. In August, I got a new, smaller cast just covering my right leg, and got my first leave home to New Mexico. Then it was back to San Diego for a few more months. Finally, late in 1966, I was fitted with an ischial weight-bearing brace and told that I would have to wear it for the rest of my life. That meant that I would never again be able to bear weight on my right leg, which could break easily and might not heal a second time. Instead, when I stood or walked, I would literally be "sitting" on the brace, bearing weight not on the leg but on the right ischial tuberosity, my "sit bone." The brace wasn't comfortable, but it gave me a lot of freedom. It was hinged at the knee so I could sit down. The brace was fitted with a special shoe which was permanently attached to it, until I needed new shoes. Very stylish.

I was finally discharged from the hospital in December and flown to the Veterans Administration Hospital in Kansas City, Missouri. Susan was already teaching in Kansas City, Kansas, and I planned to enroll at Kansas City campus of the University of Missouri.

My transfer to the VA hospital came with good news. An orthopedic surgeon told me my brace was not necessary and that I should throw it away. Susan and I were married on 27 December 1966. After our honeymoon, I began taking the brace off while I was at home in our apartment. I eventually started going out without it. At first I had a deep limp. The muscles in my right leg had atrophied and could not easily support my weight. Soon, however, I was walking almost normally and eventually was able to enjoy hiking, running, and cross country skiing.

The greater task I faced, although I did not know it at the time, was the task of putting Vietnam behind me. I was unaware that combat veterans do not necessarily have the luxury of packaging the past and putting it away in a dusty attic. It turned out that my greatest challenge lay ahead—coping with the psychological trauma of combat. 

Mr. Ingraham is now retired and lives in Vancouver, British Columbia.

In Memoriam

Dr. Hermes C. Grillo, noted thoracic surgeon on the staff of Massachusetts General Hospital, Emeritus Professor of Surgery at the Harvard Medical School, Visiting Surgeon at Massachusetts General Hospital, Emeritus Chief of General Thoracic Surgery, and former Navy surgeon during the Korean War, died 14 October 2006 in an automobile accident near Ravenna, Italy. He was 83.

Dr. Grillo was born in Boston and raised in Providence, RI. He graduated from Brown University in 1943 and Harvard Medical School in 1947. He joined the surgical house staff of Massachusetts General Hospital that same year.

Having been part of the Navy's SV-12 program during medical school, Dr. Grillo had completed 3 ½ years of his surgical residency at Massachusetts General Hospital when the Korean War broke out in 1950. By that time he had severed his ties with the Navy but with a looming military obligation, he rejoined. As he recalled in a 1999 *Navy Medicine* interview: "I'd spend one year at sea, and I like the sea. I pictured myself on a ship in the Mediterranean, of course--naturally the sun, the Med squadron, and then, a year in a naval hospital doing something moderately interesting."

But just days into his Navy career, LTJG Grillo's aspirations for a Mediterranean tour were dashed when he was assigned to the Marines. Following orientation at Camp Lejeune's Field Medical Service School, Dr. Grillo went with the First Marine Division to Korea. His introduction to the war was immediate and dramatic.

He arrived at the front in 1951 when medical services were sorely needed. The Chinese had entered the war late the previous fall and the conflict had settled down to a bloody stalemate. The young medical officer was shocked to learn that he was the only trained surgeon in his sector of the front. "It was a slaughterhouse because the Marines went up the hill against bunkers where the North Koreans were dug in. Occasionally, things would quiet down a little bit and then we would have another great run. With our limited personnel it didn't take long to absolutely saturate us."

LTJG Grillo spent his 8-month tour in Korea with D Medical Company of the 1st Medical Battalion, 1st Marine Division. It was a far cry from the sterile environment of Massachusetts General Hospital.

"We had no true operating room lights. Initially, I learned to operate with a flashlight clipped to the back of my belt. Sometimes at night the lights would go out



the generators were not dependable, and everyone would be stumbling around and I would say, 'Reach in my back pocket and you will find a flashlight.' And somebody would fumble around. I remember finishing a bowel anastomosis with this flashlight.

"We had no suction machines. So when I had a belly full of feces and exudate and twigs and blood, I would just scoop it out with my hand onto the dirt floor. And then we would take big abdominal pads and just wipe the belly out, pour saline in and clean it out as best we could. If there was a mess of bleeding welling up, all you could do was to put pressure on things and then slowly work your way in, because there was no suction of any sort available.

"There were no deep abdominal retractors. There were all these miserable little things a few centimeters long. I took some 155mm brass shell cases—which are big and heavy and long—and I drew on them outlines of retractors that I wanted. On a piece of paper I drew the curve I wanted and we took them down to the engineers. They cut these for me from the heavy brass, bent and filed them, and these are what we used."

When Dr. Grillo left the Navy wearing a commendation ribbon with a Combat V, his combat surgical experience put him in good stead for the rest of his career. Renowned as a pioneer in thoracic surgery, his 2004 textbook, *Surgery of the Trachea and Bronchi*, is now considered a landmark work in the field. But more importantly, he will be most remembered for his nearly 60-year career as both a surgeon, professor, and mentor to countless students at Massachusetts General Hospital and Harvard. He will be greatly missed. [🔗](#)

RADM Joseph L. Yon, MC, USN (Ret.) died on 10 February. He was 94 and the oldest Medical Corps flag officer. Dr. Yon was born in Coraopolis, PA, on 7 September 1912. He attended Virginia Military Institute and the University of Pennsylvania. He received his M.D. degree from the University of Virginia School of Medicine in 1937 after which he served a rotating internship at St. Francis Hospital, Pittsburgh, PA, from 1937 to 1938. He was commissioned as a lieutenant (j.g.) in the Medical Corps in 1938 and was assigned to Naval Hospital Newport, RI. Dr. Yon received his residency training at Northwestern University and Cook County Hospital in Chicago from 1948 to 1949, and at Naval Hospital, Philadelphia from 1949 to 1951.

Dr. Yon served as medical officer at several naval hospitals both in the U.S. and overseas. At the outbreak of World War II, he was serving as medical officer aboard USS *Pecos* (AO-9) with the Asiatic Fleet. His ship was in Manila Bay and engaged in the withdrawal action of the Asiatic fleet south to Java on 9 December 1941. On 1 March 1942, *Pecos* was sunk by enemy action.

After 4 hours in the oily water a passing U.S. destroyer rescued Dr. Yon and other survivors and took them to Australia. "The only thing I had were burns and a fragment in one knee. I put a couple of stitches in that myself aboard the destroyer, and that's the only injury I had," Dr. Yon recalled in a 2003 interview for the BUMED oral history project.

After serving a year ashore at BUMED, Dr. Yon again went to sea aboard USS *Miami* (CL-89) as senior medical

officer. He served aboard that vessel until the end of the war.

Dr. Yon then served as senior medical officer at the Naval Operating Base, Bermuda from 1945 to 1947 and was then assigned to Naval Hospital Corona, CA.



After completing his residency in surgery, he was assigned as head of the Department of General Surgery at Naval Hospital St. Albans, NY (1951-1952); Chief of Surgery and executive officer of USS *Consolation* (AH-15) in Korea (1953-1954); chief of Surgery, Camp Lejeune, NC (1954-1960), with additional duty as executive officer from 1959 to 1960; commanding officer, Naval Hospital, Newport, RI, from 1960-1962; and commanding officer, Naval Hospital, St. Albans, NY (1962 to 1964).

Dr. Yon was selected for flag rank and assumed command as commanding officer, Naval Hospital Portsmouth, VA, and District Medical Officer on the staff of the commandant, 5th Naval district. In 1971 he commissioned the new Tidewater Naval Regional Medical Center and became its director.

RADM Yon was the recipient of the Legion of Merit, a Secretary of the Navy Letter of Commendation with pendant, and the Purple Heart. He also received the American Defense Medal with Star, Asiatic Pacific Campaign Medal with seven Stars, American Theater Campaign Medal, World War II Victory Medal, National Defense Medal, United Nations Service Medal, Korean Campaign Medal, Philippine Defense Ribbon with one Star, Philippine Liberation Ribbon with two Stars, Philippine Independence Medal, Philippine Presidential Unit Citation, and the Korean Presidential Unit Citation. ⚓

Navy Medicine 1966

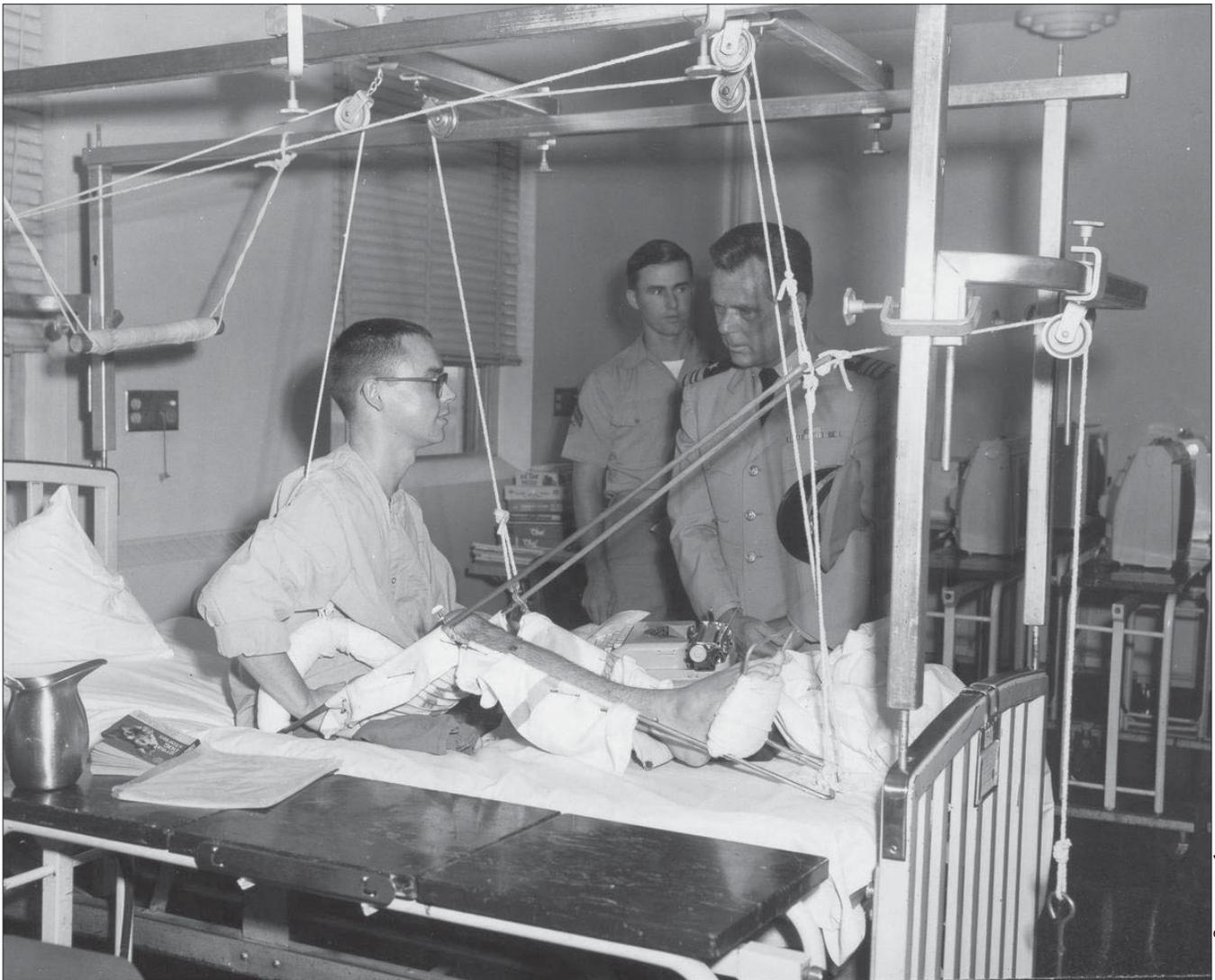


Photo courtesy Robert Ingraham

HM3 Robert Ingraham recovers from his wounds at Naval Hospital San Diego. His visitor is Navy reservist and actor, Jackie Cooper. (See story on page 27.)

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