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COVER: CAPT Albert Shimkus, NC, USN, Commanding Officer of the Medical Treatment Facility aboard USNS *Comfort* (T-AH 20). CAPT Shimkus discusses his career and the evolving role of the Navy's two hospital ships in an exclusive interview on page 25. Photo by HM2 Raphael Acosta, Navy Medicine Support Command, Bethesda, MD.



We Want Your Opinion

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

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A Look Back

Navy Medicine 1944

The Paralympic Military Summit at Naval Medical Center San Diego helps disabled veterans and active duty personnel, many of them amputees from the war in Iraq, strengthen their lives through sports clinics and team building.



Keith Kennedy, U.S. Paralympics head coach, demonstrates proper stroke technique to war-wounded veterans prior to the Paralympic Military Summit swim competition. Photo by MCSN James Seward



Navy Hospital corpsmen help LCPL Patrick Meyers in and out of the water. Photo by MCSN James Seward



MAJ Anthony Smith practices his backstroke technique. Photo by MCSN James Seward

NAVMED MPT&E Command Established

The establishment ceremony for the new Navy Medicine Manpower, Personnel, Training and Education Command (NAVMED MPT&E) took place 4 October at the National Naval Medical Center, Bethesda, MD.

After reading his orders in front of a packed audience, CAPT Roberto Quiñones, Jr., became the commanding officer.

NAVMED MPT&E will work hand in hand with the Naval Personnel Development Command and the Naval Personnel Command to execute the manpower, training, and



“CAPT Roberto Quiñones, Jr. addresses the audience after taking command of NAVMED MPT&E.” Photo from NAVMED MPT&E

education mission for Navy medicine. This command is the newest step on a path toward the Chief of Naval Operations’ (CNO) vision of a comprehensive career and development and management system.

The formation of this new command involves the integration of approximately 25 personnel from the Bureau of Medicine and Surgery’s (BUMED) Human Resources Division (M1) with major elements of the former Naval Medical Education and Training Command. In addition to the augmentation of the Administrative and Resources Directorates, the new command is organized into the following four major directorates: Functional Integration, Workforce Development, Workforce Management and Transformation.

With the stand up of one command, comes the disestablishment of another. RDML Carol I. Turner turned over her command of Naval Medical Education and Training Command to CAPT Quiñones, and offered her support for the new command and the important work ahead. “It’s difficult to let go of what was. The light here is that we are building something better, more aligned and more focused on today’s environment. NAVMED MPT&E is clearly the next step in aligning and focusing our resources,” she said.

“What this does is, it allows us to surge to the future,” CAPT Quiñones explained. “This ensures we have the right

sailor with the right skills at the right time for the right job, and that’s exactly what we’re going to do.” 

—Story by Navy Medicine Support Command Jacksonville Public Affairs.

Sharing Experiences

Are you planning a vacation? Or perhaps your next adventure in the Navy? Are you deploying? How do you know you’re ready? Wouldn’t it be nice to have some information before you arrive in theater? The Naval Operational Medical Lessons Learned Center (NOMLLC) is your resource for information from those who have been there before you. This is only one of many features NOMLLC offers. Other features include a search engine for information on various subjects (not limited to Navy) and a forum where observations and lessons can be shared and discussed.

In today’s world, “operational” is key. Some people deploy frequently, but some are preparing for that first deployment. The experience of “getting ready” can be full of apprehension. Logging onto NOMLLC’s website is a great resource for first-time deployers. Find out what you need to bring and what to expect when in theater. Reading and learning from other people’s experiences is a smart way to prepare and alleviate some of the anxiety.

The medical lessons learned system is a very useful search engine. Simply type in a word you are interested in and the search is on! The system has a daily digest feature enabling you to select up to 10 search terms based on your area of interest. Any time your topic of interest is posted on the site, you receive an instant email with a link to the new lesson!

NOMLLC also provides a forum allowing discussion with general access (anyone can view and make inputs). This feature also allows you to register anonymously! If you are interested in becoming a moderator for a particular discussion group, please contact a member of the MLL staff at mllstaff@nomi.med.navy.mil or 850-452-7716.

Come visit the site for yourself to view firsthand the many features offered. Whether you have a lesson or observation you’d like to share, or are simply looking for additional information on a particular subject, this site can be of assistance. You can access the website at <https://mll.nomi.med.navy.mil> or simply go to Google and type in “medical lessons learned”! Please remember that if people do not use this tool then this great resource will go dry. 

—By CDR Lena Hartzell, DC, USN, Future Plans and Strategies (M5), Bureau of Medicine and Surgery, Washington, DC.

Canadian Corpsman Trains Aboard *Boxer*

Leading Seaman Michelle Verville, a Royal Canadian Navy medical technician from HMCS *Ottawa* (FFH-341), one of the assets of *Boxer* expeditionary Strike Group (BOXESG), visited USS *Boxer* (LHD-4) to train with the ship's medical department. She flew over via helicopter from the Canadian frigate to tour *Boxer's* medical facilities, learn how *Boxer* responds to trauma and injuries, and observe how *Boxer's* medical team trains.

Verville is one of only two medical providers for *Ottawa's* crew of nearly 250 sailors. Visiting *Boxer* gave her the opportunity to see how medical staff provides healthcare for nearly 3,000 sailors and Marines. "I wanted to work with the staff here and see how different our training is," said Verville. "Even though the medicine is similar, we train quite differently."

Ottawa's medical training program is structured around a classroom setting, where *Boxer* uses on-the-job training. While aboard, Verville observed multiple surgeries, assisted with daily patient care, and responded to a medical emergency. "It was great working with *Boxer* sailors and Marines to see how they do business here," said Verville. "I learned a lot from their experience and how they operate so effectively."

Because *Boxer's* medical facility is one of the largest in the U.S. fleet, it has far more capabilities than *Ottawa*, such as a radiology department, operating rooms, and laboratories. Verville was able to experience how extensive at-sea medicine can be.

Both ships operating in the U.S. 7th Fleet area of responsibility, know that they can play a vital role to aid humanitarian assistance operations, medical evacuations, or combat medical support that would rely heavily on the medical capabilities of the *Boxer* strike group. Cross-training sailors from ship-to-ship helps ensure the success of the strike group should it have to respond to any medical scenario, according to HMCS Steven Richardson, leading chief petty officer of

Boxer's medical department. "Training is a necessary part of any evolution," said Richardson. "Anytime you work with another nation, it's important that we understand each other's capabilities, so in the event anything occurs we know where our assets are."

The cross training also fostered cooperation between the two allies which provided Verville and *Boxer* corpsmen a forum to learn about each other's navies and each other's culture. "So long as nations have good working relationships, it's going to be easy to get people taken care of, and taking care of people is our primary job," said Richardson. "It doesn't matter if they're American, Canadian, or Iranian." 

—Story by MCS Joshua Valcarcel, USS *Boxer* Public Affairs.

Essex Demonstrates Medical Readiness

USS *Essex's* (LHD-2) medical department was put to the test with numerous mass casualty drills during the blue/green work-ups with the embarked 31st Marine Expeditionary Unit (MEU) 9-10 October.

Essex is the Navy's only forward-deployed amphibious assault ship, but the ship has an additional, important role as a hospital ship, second only to the actual hospital ships USNS *Mercy* (T-AH 19) and USNS *Comfort* (T-AH 20). "With each drill, we evaluate ourselves and try to find better ways to integrate our people into a team that can receive casualties, stabilize them, and then provide definitive care or send them where they can receive that care," said CDR Brett V. Sorter, *Essex's* senior medical officer. "By integrating a blue-green medical team afloat, we learn better how to 'package' and 'receive' patients from one to another as an efficient team."

The ship has three operating rooms, a 14-bed intensive care unit, a 45-bed ward, a radiology suite, and a blood bank with more than 600 units of frozen blood. Sorter additionally noted that the personnel assigned to the medical department



Seaman Michelle Verville administers intravenous fluids to SGT Corey Schwendeman. Verville visited *Boxer* to train with the ship's medical departments on patient care techniques. Photo by MCS Joshua Valcarcel



Boxer medical team prioritizes severely injured personnel to be taken down to medical during a mass casualty drill. Photo by MCS Jhoan M. Montolio (RELEASED)

are extremely talented. “The personnel we have on board are as impressive as our equipment and capabilities,” said Sortor. “We are fortunate to have corpsmen with experience in physical therapy, optometry, and ultrasound technicians. Other corpsmen have spent time in the field with the Marines and they know combat casualty care. Bottom line, the *Essex* medical team has the skills, facilities, and desire to provide the best care possible to our shipmates should the need ever arise,” he added.

Essex is currently transiting to the Republic of the Philippines area of operation to participate in Amphibious Landing Exercise (PHIBLEX)/Talon Vison as part of the annual fall patrol. 

—Story by CMCS(SW/AW) Christina Johnson, USS *Essex* (LHD-2) Public Affairs.

Camp Pendleton EMT Course Top in the Navy

During a recent National Registry Emergency Medical Technicians Organization conference, Naval Hospital Camp Pendleton’s (EMT) Basic Program was recognized as the number one EMT-Basic Program in the Navy. “Being acknowledged as one of the top programs in the nation really recognizes the students. It shows the dedication they have and their accomplishments,” said HM1 Martin R. Villanueva, course coordinator and lead instructor.

The program was ranked as one of the top 12 programs from among 8,000 EMT Programs nationwide. This honor was based upon the hospital’s sustained superior performance, as they have achieved a 95 percent average passing rate on the National Registry examination consistently over the last 3 years.

The course is designed to train emergency personnel and staff at the naval hospital, fire crash rescue, and any other service members whose job requires EMT certification. The service members enrolled in the course go through a condensed 18 training day version of the National Registry of Emergency Medical Technicians course. The NREMT course lasts an entire semester. Students are graded on five different exams and must maintain a 70 percent average.

The hospital tests students everyday and they must maintain an average of 80 percent or above. If a student falls below 80 percent, they are given many opportunities to bring their grades up. Tutoring is made available, extra homework is given to ensure they understand the material, and instructors make themselves available for after school help.

“From start to finish the course is very intense and fast paced; every day is something new and they are constantly learning. There is also an additional 25 hours more than what the NREMT requires,” said Villanueva. “The reason the course is so successful is because we have a very dedicated core group of instructors. We have highly motivated individuals who want to succeed.”

“The students understand the importance of having this knowledge,” said CDR Constance L. Worline, EMT program director.

Along with the in-house training, students must stand 2- to 4-hour emergency room duties and one, 8-hour ambulance duty. They are evaluated on their performance during these duties. Upon completion of the course, the students must take the NREMT exam in order to become certified EMTs. That is where the hospital has been so successful, because they train the service members and constantly reiterate information.

“We do the best we can for students no matter what the situation is,” said Villanueva. 

—Story by LCPL Stephen McGinnis, Consolidated Public Affairs Office, Marine Corps Base Camp Pendleton.

NHB Support Group Takes Healthy Hints to Heart

The motto being followed by staff and patients, caregivers, care-receivers, and care-sharers is “to thrive, not just survive!”

And that is exactly what they all are doing, with the Naval Hospital Bremerton Health Promotion department providing the ways and means. NHB Health Promotion has started a new awareness campaign called Healthy Habits, which takes place on every third Thursday of each month, from 1215 to 1245.

The monthly feature, part of the Living Well with Diabetes Program, has been specifically organized to allow members of the Diabetes Support Group to have opportunities to pitch in, take the lead, and share with others.

“Our support group members know so much and have so much to offer others,” said Janet Mano, Health Promotion coordinator. “This is a perfect way for them to be a presence and reach out to get to others much like them who just might be hesitant to talk with a health educator.”

According to Mano, support group members will choose upcoming topics of interest, all with the common theme of how to live healthier. “Even if a person doesn’t have diabetes, they can come and join us,” she said.

“This course has been very helpful,” stated David and Barbara Galligan, of Seabeck. The self-professed ‘snow-birds’ will take their acquired knowledge with them when they depart for the warmer climes of Tucson, AZ. “We’ve been attending the pre-diabetic exercise class, and learning more on our dietary considerations. The more knowledgeable we get on how we can improve our health, the better off we will be.”



David and Barbara Galligan of Seabeck sift through grain examples to participate in the NHB Health Promotion “Guess the Grains” contest. Photo by Douglas H. Stutz

Featured in the initial Healthy Habits was the benefits of cooking with flaxseed, which also included information on other grains. Francisca Matanane, from Gig Harbor, won the “Guess the Grains” contest. She correctly identified the following six grains: millet, rice, barley, regular oatmeal, steel cut oats, and quinoa.

Health promotion staff and the support group have been proactive in pointing out that whole grains are loaded with vitamins, minerals, antioxidants, and fiber. Eating a whole grain, such as oatmeal, for breakfast is an easy way to get the healthy benefits. Adding a small amount of ground flaxseed to our food is another easy way. An additional benefit of flaxseed is the presence of heart healthy omega 3 monounsaturated fat. ⚓

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

Navy Medicine at Forefront of Global Disaster Relief Demo

With the number of natural disasters striking the globe in recent years, it can tragically be said that the world’s disaster relief groups have been getting a lot of practice lately. Among the relief leaders getting the most experience is Naval Hospital Bremerton’s CDR Eric Rasmussen. Based on years of recent “lessons learned,” Rasmussen directed the “Strong Angel III” global disaster relief demonstration in San Diego in late August.

It was the third such event since Rasmussen organized the first Strong Angel demonstration in 2000. The demonstration had multiple sponsors but the largest was within the Office of the Secretary of Defense, Dr. John Grimes, Asst Secretary of Defense for Networks and Information Integration (ASD-NII), the CIO for the Department of Defense. After 8 months of nights-and-weekends planning, the 11 members of his executive team coordinated more than 800 participants from 270 organizations in 8 countries. Several global relief organizations were represented in a demonstration that simulated post-disaster conditions and explored ways of dealing with the situation.

“This time we specifically looked at community resilience,” said Rasmussen. “What can a community do to be self-reliant until the cavalry comes? And we came in on time and under budget. The results have been very rewarding.”

With 49 total objectives to the demonstration, Rasmussen said the general goal was to recreate a post-disaster scenario similar to that he experienced in Waveland, MS, after Hurricane Katrina. There, the city’s civic core had been wiped out, leaving the small town without rescue resources while it waited for a FEMA response.

Rasmussen’s disaster relief experiences began in the 1990s while he was serving as the Fleet Surgeon for the Third Fleet. Responsible for the Pacific Rim theater, Rasmussen’s admiral,



CDR Eric Rasmussen. Photo by Douglas H. Stutz

the Commander of Third Fleet, tasked him with coming up with a plan for disaster relief in the area.

Eventually, the Secretary of Defense himself became interested in Rasmussen’s work and asked him to provide some lessons learned from recent disaster relief efforts. This led to his first Strong Angel demonstration and the creation of the 10-20-30 document: the 10 commandments, 20 recommendations, and 30 advisories for civil-military interaction.

“When we boil that down, we wind up with effective guidelines that are now being used around the world,” he said.

With this third Strong Angel event, Rasmussen and his team again were in a position to define future disaster relief efforts. The new DOD policy gives equal importance to relief operations as to combat operations, and the efforts put forth in Strong Angel III have already raised awareness on several levels around the world.

The exercise generated a steady flow of external media interest, with very positive articles in *The New York Times*, the *International Herald Tribune*, CNN, Reuters, *Government Computer News*, *Federal Technology Week*, and others, along with discussions captured from more than 500 blogs. Some of that can be viewed on the associated website, www.strongangel3.net. ⚓

—Story from Naval Hospital Bremerton, Public Affairs Office.

Fighting the “Crud”

Phases two and three of FDA-approved trials of a drug developed to stop the traditional “boot camp crud” began 7 October at Navy Recruit Training Command Great Lakes, IL. The vaccine could eventually reduce illness in as many as one out of five sailors entering the Navy.

The adenoviral illness is caused by viral pathogens, or germs, that can make sailors sick, said CDR Kevin Russell,

a medical epidemiologist from the Naval Health Research Center (NHRC) in San Diego. He is the Navy's lead physician, overseeing the Navy's portion of the Army-led joint Army/Navy trials.

To ensure safety and effectiveness, several studies, or "trials," must be conducted before the vaccine is licensed by the Food and Drug Administration. Phase one saw 58 volunteer Army medics as subjects and was completed in 2004. Russell said phases two and three should be complete in late 2007.

"Careful FDA-licensing trials take many years," Russell explained. "The adenovirus vaccine trials are on an accelerated schedule. Use of vaccines in all recruits may begin in 2009."

Russell said an estimated 10-20 percent of all recruits lose some time from training due to adenoviral illness, clearly impacting recruit training success and readiness.

"Two types of the pathogens--serotype-4 and serotype-7--have a long, long history of making military recruits sick with fever, sore throat, cough, and sometimes upset stomachs and other symptoms," Russell said. "Recruits with adenoviral illness usually feel sick for 3-10 days, and this can impact their training."

The goal of the trials is to replace oral vaccines that were given to U.S. military recruits from 1971 to early 1999. NHRC surveillance of the illness from 1996-2001 determined that the adenovirus illness was still a problem and thus a vaccine was still needed.

"Unfortunately, the only manufacturer of adenovirus vaccines stopped production in 1996, and the U.S. military had to work to find a new manufacturer when the last of the vaccine supply ran out in 1999," Russell said.

The Department of Defense has funded the company Barr/Duramed to be the sponsor of the adenovirus vaccine trials and eventually to manufacture the vaccines.

Russell's Navy adenovirus vaccine trial staff is 2 active duty physicians, 11 full-time contractors, and 110 part-time contractors. His team is working closely with the Army Medical Research and Materiel Command in Fort Detrick, MD, and researchers from the Walter Reed Army Institute of Research. The Army trials are being conducted at the Army Basic Combat Training Center in Fort Jackson, SC.

The NHRC has a long history of successful research on respiratory infections, especially adenoviral infections, and NHRC houses the Navy Respiratory Disease Laboratory, Russell said, making it the ideal partner with the Army research team.

"Approximately 4,000 recruits will participate in these studies," he said. "Rigorous review and safeguards are in place to ensure that recruits who participate do so voluntarily and safely. More than 100 research professionals are working on these complex studies at each site because re-acquisition of safe and effective adenovirus vaccines is a very high priority for the U.S. military." 

—Story by Larry Coffey, Navy Medicine Support Command Public Affairs Officer, Jacksonville, FL.

Groundbreaking to Mark New Era in Military Healthcare Education

On 23 October, U.S. Senators Daniel K. Inouye (D-HI), Barbara A. Mikulski (D-MD), Paul S. Sarbanes (D-MD) and Representative Chris Van Hollen (D-MD), along with Department of Defense Assistant Secretary for Health Affairs William Winkenwerder, Jr., M.D., other military leaders and dignitaries helped the Uniformed Services University of the Health Sciences (USHS) celebrate the groundbreaking of its new Academic Program Center.

USUHS's newest facility, the first to be constructed on campus since the school was built in 1978, will accommodate the growth in the number of degree-granting programs offered by the university. The three-level structure will provide extra classrooms and faculty accommodations for USUHS' newest school, the Graduate School of Nursing, as well as Graduate Medical Education programs, and Continuing Health Education. The facility is expected to be completed within the next 2 years.

USUHS is the nation's only federal school of medicine and graduate school of nursing. The students are active-duty uniformed officers in the Army, Navy, Air Force, and U.S. Public Health Service who are being educated to deal with wartime casualties, national disasters, emerging infectious diseases, and other public health emergencies. Many of the university's graduates are currently serving on the battlefields in Iraq and Afghanistan. Currently, the chief military medical officers serving in Afghanistan, Kuwait/Qatar, and the horn of Africa are USUHS alumni.

"The university is at the forefront of education and research in military medicine," said Charles L. Rice, M.D., USUHS president. "This new facility will provide space to allow the university to continue to fulfill its essential mission in educating men and women who are learning to care for those in harm's way."

For more information about USUHS, please visit the website at www.usuhs.mil. 

—Story from the Uniformed Services University of the Health Sciences Office of External Affairs.

Navy Researchers Report a Potentially Effective Treatment Approach for Bird Flu

A team of scientists from the Navy, Army, and Protein Potential, LLC report that a treatment used during the Spanish flu pandemic may also be effective for current bird flu patients. The authors analyzed medical literature contained in the Navy's Bureau of Medicine and Surgery Library and Archives that was originally reported during the Spanish Flu pandemic of 1918-1920. They found that transfusions with blood products obtained from Spanish influenza

survivors may have reduced the risk of death in seriously ill Spanish influenza patients. The study was published in the 29 August 2006 online edition of the *Annals of Internal Medicine*. The team of researchers includes team leader, LCDR Thomas C. Luke, MC, USN; CAPT Edward M. Kilbane, MC, USN; COL Jeffrey L. Jackson, MC, USA; and CAPT Stephen L. Hoffman, MC, USN (Ret.), currently the Chairman of Protein Potential, LLC.

The scientists used clinical data generated during the 1918-1920 Spanish influenza pandemic, indicating that treatment of patients with hyper-immune blood, plasma, or serum from recovered Spanish influenza patients reduced mortality in seriously ill patients by approximately 50 percent.

Based on these findings, the scientists propose studies to determine if treatment of patients with convalescent plasma containing anti-H5N1 antibodies from recovered patients could lead to a similar reduction in mortality for bird-flu patients. "During the last 1-2 years, patients in Indonesia with avian influenza have had mortality rates of 50-75 percent demonstrating the need for an effective treatment," according to Dr. Hoffman of Protein Potential.

"Plasma is produced in local hospitals worldwide and transfusions might be useful in treating bird flu patients during outbreaks and pandemics, especially in light of the limitations of existing treatment options" said Dr. Thomas C. Luke. "A single recovered bird-flu patient could donate a weekly volume of plasma sufficient to treat many patients with H5N1 influenza."

The article titled "Convalescent Blood Products for Spanish Influenza Pneumonia: A Future H5N1 Treatment?" was published in the 17 October 2006 print edition of *Annals of Internal Medicine* and is currently available at <http://www.annals.org/cgi/content/full/0000605-200610170-00139v1>.

—Story from Bureau of Medicine and Surgery Public Affairs Office.

National Naval Medical Center Dentist Helps U.S. - Japan Relations

A unique sailor shared his experiences as a resident at the National Naval Medical Center's Naval Postgraduate Dental School with a small group of Japanese college students 17 August.

Japanese CDR Hiromichi Iizuka is the first dentist from the Japanese Defense Force to attend the school. The Japanese students were visiting the United States to see firsthand how relations between the two countries has shifted since World War II.

Iizuka, accompanied by Bethesda's Comprehensive Dentistry Director CAPT Donald Worm, escorted the group and their college professor around the Naval Postgraduate Dental School.

Iizuka specializes in General Dentistry and describes himself as an "icebreaker." He wants to learn about the

U.S. system and apply the knowledge to his native Japan, he said. "I am studying both dentistry, and the organization and operation of the U.S. Navy Dental system," Iizuka said.

"I have two points for the student tour. Both the dental and military aspects are important."

The tour took place only days after the anniversary of the Japanese surrender ending World War II. Iizuka wanted to emphasize the changes that have occurred in relations between the Japanese and U.S. military over time. "Japan and the U.S. have a long history," Iizuka said. "I want to show improvement over time — new versus old."

Iizuka cannot treat patients because the American Dental Association does not recognize his Japanese dental license, Worm said. The focus of his experience in the United States is broader than that of a typical resident. "He has been on USNS *Comfort* (T-AH 20)," Worm said. "We're hoping to get him over to the Pentagon, on a carrier, and possibly doing something with the Marines."

Worm attributes the international dental relationship to the Navy Dental Center Japan and the close ties it has formed with its Japanese counterparts. That relationship, which is approximately 7,000 miles away, is yielding benefits to Bethesda's dentists. Iizuka has given lectures on Japanese dentistry and technology, Worm said. "We're exchanging ideas, concepts, philosophies," Worm said. "It's also beneficial for our residents that might be heading to Japan."

Japan's national health insurance supports the Japanese Defense Force in providing dental care to active duty and family members. ⚓

—Story by Jen Hunter, National Naval Medical Center Public Affairs

Sailors Adopt Family Care Plans to Promote Security at Home and Abroad

Sailors attended family care plan training held by the Fleet and Family Support Center 12 October at Naval Base San Diego. Sailors and command family care plan coordinators learned about the guidelines and resources available to those who fall under the family care plan policy. "We are helping each other take care of our families during deployment," said Master-at-Arms 1st class (SW) Michael Hill, the command coordinator for San Clemente Island.

The Navy Family Care policy (OPNAVIST 1740.4B) requires all Navy personnel, active and reserve, who are single parents or part of a dual military couple with custodial responsibility for family members, or sailors who are the sole care giver of another person to arrange support for their family during deployment, normal and extended working hours, temporary assigned duty assignments and weekend duty regardless of whether the sailor is on shore or sea duty.

"Being ready at all times is important because you can be called to duty at any moment, and sailors need to make sure

their families are taken care of while they are away,” said Mercedes Carmona, a Fleet and Family Support Center information and referral specialist. “The command coordinator is a crucial part of a successful family care plan because they have the tools and resources necessary to establish a plan.”

Early family care planning is essential to combat readiness by ensuring sailors and their families are prepared for deployments, and are ready to execute their military and professional duties without worrying about whether their family members are taken care of.

“The family care plan helps prepare families to deal with what comes their way,” said Kim Czaja, Ombudsman for Navy Region Southwest. “For those of us on the outside it puts a plan in place so when our family leaves there is less to worry about.”

For more information about the Navy Family Care policy contact your command coordinator or the Fleet and Family Support Center at www.cnsw.navy.mil/fsc/fsc.htm. 

—Story by MCS Chelsea J. Kennedy, Fleet Public Affairs Center, Pacific.

Large Feat for Little Feet: *Mercy's* CIVMARs Distribute Shoes to Children at Humanitarian Stops

Under West Timor’s bright noon sun, two of hospital ship *USNS Mercy's* 66 civil service mariners distributed 40 pairs of shoes to local children, the ship’s third day of humanitarian operations in Kupang, Indonesia.

Mercy recently completed a 5-month mission providing medical assistance to the people of Southeast Asia and the Pacific Islands. Navy doctors and civilian volunteers staffed the hospital while *Mercy's* CIVMARs [civilian merchant mariners] operated and navigated the ship. They also participated in the humanitarian efforts and, as in this case, initiated goodwill projects of their own.

“After visiting our first few stops in the Philippines and seeing so many kids without shoes, the deck day workers all started talking about doing something,” said Chief Mate Michael Keller. “We would hand out candy and fruit to the kids, but wanted to give them something more permanent.

The shoes were purchased in Singapore with money pooled by the civil service deck day workers. Boatswain’s Mate Renato “Speedy” Gonzalez, Able Bodied Seamen Timothy Wheelock, Dale Witham, Gregory Barrett, Oliver Jones, Nathan Wood, Third Mate Richard Paramore, and Boatswain Tommy Payne donated about \$500, which was matched by Keller for a total reaching nearly \$1,000.

That money bought 150 pairs of shoes, still in the boxes, from a store owner who gave Keller an excellent deal when the businessman learned the intended purpose of the shoes.

Then the fun of distributing the shoes began. For one afternoon at each stop, Keller, with the help of one or two other deck workers, set up their small distribution center.



Civil service mariner Michael Keller, *USNS Mercy's* chief mate, distributes shoes to children in Kupang, Indonesia. Keller and eight of *Mercy's* other CIVMARs pooled their money to purchase 150 pairs of shoes in Singapore which have been distributed at five stops in Indonesia. Photo by Laura M. Seal, Military Sealift Command

In Kupang, Renato Gonzalez and Michael Keller took a short break in the afternoon from their main duty of ferrying patients and medical personnel to and from *Mercy* in two 10-foot utility boats called the “Band-Aids” to distribute the shoes.

“We set-up near the pier rather than at the hospital because this way *Mercy* is touching even more people,” said Keller. “The patients at the hospital are already being helped, and we wanted this mission to bring joy to as many people as possible.”

They didn’t have to advertise or wait around long. “You’d be amazed how fast the word gets out,” said Keller. “A couple of kids get shoes, tell their parents, and soon the whole neighborhood comes.”

The CIVMARs distributed 110 pairs of shoes at five stops in Indonesia, and 40 pairs at *Mercy's* final stop in Dili, East Timor. 

—Story by Laura M. Seal, Military Sealift Command Public Affairs

USNS *Mercy* Finishes 72 Days of Humanitarian Aid

The last of *Mercy's* patients returned to shore 1 September as the ship prepared to make its journey home after completing 72 days of humanitarian aid to Southeast Asia.

During its 5-month humanitarian and civic assistance deployment, *USNS Mercy* reached thousands of people in the Philippines, Bangladesh, Indonesia, and East Timor. *Mercy's* crew not only treated an unprecedented number of patients during a single deployment, but it also brought medical education, civil engineering, culture exchange, and most of all friendship to the people of the region, according to CAPT Bradley Martin, the hospital ship’s mission commander.

“We’ve achieved a tremendous amount,” said Martin. “We’ve delivered care to almost 200,000 people. We’ve done lifesaving surgeries for people, and we’ve altered people’s lives in a lot of positive ways.”

“Another thing that has been very important with this mission is that we have achieved a high level of interoperability with the NGOs [nongovernmental organizations] and allied militaries,” continued Martin. “We’ve gotten a lot done, and I hope to foster and continue relationships with all these countries and their people.”

To carry out the medical side of its mission, *Mercy* tied together the skills of U.S. and foreign military medical specialists with doctors and nurses of nonprofit, charitable medical organizations, most of which operate independently in the region.

The organizations working aboard *Mercy* included Project HOPE, Operation Smile, Aloha Medical Mission, Tzu Chi Foundation, International Relief Teams, the UCSD Pre-Dental Society, and a number of host nation NGOs. *Mercy*’s military medical team consisted of U.S. Navy, Air Force, and Army members along with foreign military medical personnel from Canada, India, Australia, Singapore, Indonesia, Malaysia, Bangladesh, and the Philippines.

“We have all learned a lot from each other,” said Project HOPE volunteer Michele Okamoto, a certified emergency nurse. “As for Project HOPE, we were the first NGO to work this closely with the Navy, and that’s a real source of pride for all of us. We’re really grateful for the opportunity to serve in this way because what *Mercy* has done is a great thing, and there should be a lot more of these (deployments) in the future.”

Mercy conducted a few operations each day at every location where teams conducted medical and dental civil action projects (MEDCAPs), and provided healthcare at local hospitals. The MEDCAPs, usually set up in remote villages, were used to treat minor illnesses and tooth decay ashore. When serious problems were encountered, the patients would be brought to the ship either by helicopter or small boat for further medical treatment or for surgery in one of *Mercy*’s operating rooms.

Following treatment aboard the ship, patients would be monitored in a recovery room and then be moved to one of the intensive care units on board. Patients and their escorts would wait to depart the ship in one of *Mercy*’s wards until they were fully recovered. One of *Mercy*’s last patients, Melina Barreto, expressed her thanks to those that helped her before she went home.

“It’s very lucky (for us) because you come here, and it’s free treatment for my baby,” said Barreto, an East Timorese who brought her 15-month-old child, Algira, to the hospital ship for surgery. “It’s very expensive for this surgery (at home). In our hospitals, our equipment is not complete. I would hope this ship could stay for a long time. I hope that you would come back here again.”

At each port where the medical teams disembarked to treat the sick, teams of public health workers followed close behind to test each area’s water sanitation and examine the level of insect-borne diseases. In addition, the crew held

classes to help improve current sanitation conditions as well as exchange ideas on topics such as basic life support and neonatal resuscitation.

In complement to the health-based services, *Mercy*’s crew of Seabees also helped local communities by building and repairing infrastructure and hospital facilities as well as installing various pieces of equipment. The ship’s 15 Seabees are from Naval Mobile Construction Battalion Four Zero, based out of Port Hueneme, CA. The Military Sealift Command’s (MSC) civil service mariners (CIVMARs) who operate and navigate the ship worked closely with the Seabees on many community relations projects ashore. According to Construction Electrician Chief Mike Gallagher, the assistant officer in charge of *Mercy*’s team of Seabees, he and the other Seabees benefited tremendously from the expertise of the CIVMARs.

“Together with the CIVMARs, we have built a lot of things here and improved the quality of living for the people in the places we’ve visited,” said Gallagher. “But the most important thing we’ve built was friendship with the people we helped.”

The U.S. Navy Showband, which deployed with *Mercy*, brought music to each of the countries the ship visited. They played sets that included songs from classic to current to appeal to all ages of the audience. The band also held clinics and master classes for local aspiring musicians.

Mercy’s size made it much too large to moor pier side at many of the locations. In response, the vessel embarked Helicopter Sea Combat Squadron 25, which operated two helicopters that shuttled personnel and patients to and from shore sites. The vast majority of people were transported between ship and shore by two boats, called the “Band-Aids,” run by *Mercy*’s CIVMARs. These boats transported more than 6,000 patients and personnel plus cargo.

The crew was also host to numerous guests and distinguished visitors including the presidents of the Philippines and East Timor, U.S. ambassadors, the Chief of Naval Operations, the Surgeon General of the Navy, the U.S. Pacific Command Commander, and the Pacific Fleet Commander.

Mercy returned to its homeport of San Diego in late September where most of its military crew returned to the shore-side hospitals they worked at before the deployment. The civilian volunteers returned home.

“It has been a once-in-a-lifetime experience,” said Navy corpsman Melisa Espinosa, who worked in *Mercy*’s casualty



Dili, Timor Leste. LTJG Catherine Soterias observes as CDR Dale Szpisjak administers anesthetic to one of the last patients to be treated aboard USNS *Mercy* (T-AH 19) before *Mercy*’s departure. 31 August 2006. Photo by MCS Joseph Caballero

receiving department, which is roughly equivalent to an emergency room. “I feel really lucky to be able to see all these parts of the world and be able to make new friends there. It has been one of the best things I’ve ever done, and I’d definitely do this again in a heartbeat.” ⚓

—Story by MCSN(SW) Joseph Caballero.

USNS Comfort Hosts Course for Military, Civilian Agencies

USNS *Comfort* (T-AH 20) hosted about 30 Defense Department personnel 21-23 August for training on how the Navy streamlines patient care and tracks patient movement while deployed.



Representatives from the Navy Surface Warfare Medicine Institute boarded the ship to teach the Medical Regulating and Patient Movement Courses. The course had a decidedly joint flavor as members from various defense agencies participated, including the Federal Emergency Management Agency, U.S. Public Health Service, National Guard and active-duty Navy, Army, and Air Force.

According to *Comfort's* Senior Enlisted Leader HMCS(SW/SS) Anthony Aubright, the significance of the joint training cannot be overstated. “It’s important to make everyone aware of the capabilities of each (military and government) service’s equipment and personnel for reacting to another natural or man-made disaster,” said Aubright.

Course instructor LT Ed Jiminez said the course material is based on the Navy’s “lessons learned” during Iraq and Afghanistan experiences and added other agencies, especially civilian organizations like the Federal Emergency Management Agency, are looking to incorporate some of the Navy’s medical regulating and patient movement. “Although we don’t have actual patients to work with, (the course) is able to mimic the stress level involved in regulating patient movement in a fast-paced combat environment,” Jiminez said. “This is a good way to evaluate a person’s decision-making process during an actual event.”

U.S. Public Health Service’s CAPT Stephen Formanski said the course is an opportunity for sharing of information and understanding what other services have to offer. “Patient movement is what National Disaster Medical Service (NDMS) does, so understanding what the military does for patient movement seems logical,” said Formanski, NDMS emergency coordinator for the Mid-Atlantic States. “As we learn more about other agencies’ capabilities, we’ll translate it into something we can use.” ⚓

—Story by MCS1(SW/AW) AnTuan Guerry, National Naval Medical Center Public Affairs

Last Boat From Beirut

Following the eruption of hostilities in Lebanon in July, Navy Reservists of NAVCENT Operational Support Detachment BRAVO got the call to deploy RAF Akrotiri, Cyprus to lead the Noncombatant Evacuation Operation (NEO) for American citizens trapped by the fighting. NAVCENT Det BRAVO, based in Tampa, FL, answered the call with 22 Reservists. By 21 July, 12 unit members arrived in Cyprus to augment CTF59’s NEO operations in progress while another 10 arrived the following week to support the NAVCENT staff in Bahrain.

Critical to this effort was securing the health and ensuring the well-being of the thousands of Americans being evacuated during the round-the-clock operation. Leading Det BRAVO’s medical team as a physician assistant and assisted by HM3 Mike Dogoda, we joined immediately with the Air Force’s expeditionary medical team already in place. Our challenge as a Joint Medical Force, was to provide medical coverage at four locations around Cyprus and on the various transport vessels going into Beirut. The CTF 59 also integrated Navy and Air Force Medical Planners.

On the 25th of July, we were assigned to *Vittoria M*, one of the civilian contract vessels sailing to Beirut to embark American citizens for the trip back to Cyprus - and safety. In addition to my medical team, members of the Maritime Security Detachment 21 were also on board to provide security for the vessel.

The skyline of Beirut became visible and *Vittoria M* approached the dock. Sailing thru the harbor, vessels from Canada and France were noted embarking their citizens as well.

After securing the vessel, *Vittoria M* was met by members of the U.S. Embassy. After clearing security, the evacuees were helped aboard and we offered medication for motion sickness as they settled in for the voyage to Cyprus.

The evacuees who were largely unaccustomed to being at sea, and whom had been awake for several days while traveling thru Lebanon to reach Beirut, began to succumb to motion sickness. The problem soon spread to all 250 passengers, presenting us with a challenging eight hour trip.

Of concern to us were the very young and very old travelers. The possibility that they might succumb to dehydration given the combination of stress, heat, and motion sickness was very real. They lacked the ability to handle oral fluids and after a few hours on board did not even want to try sipping liquids. Assurance was given that they would recover quickly when on solid land.

While en route to Cyprus, some of the passengers related stories of life in Lebanon and the dangers they faced while getting to Beirut. The diversity of the passengers was best described by the many languages required to communicate with them. “We spoke to them using English, French, Arabic, and Spanish. Just letting them vent was the best medicine we could provide and we learned a lot about life in the southern part of the Lebanon” said HM3 Dogoda. The passengers



Beirut at dawn. Photo by LT Mark Ingram

were glad to leave the war zone but were also full of grief as many of them had homes and family still in Lebanon.

Late in the day on 25 July, *Vittoria M* arrived in the port of Limassol, Cyprus and was again met by U.S. Embassy and Cypriot Customs officials.

The medical teams of CTF59 continued to operate 24 hours a day out of RAF Akrotiri, supporting every mission into Lebanon and every flight out of Cyprus until the NEO operation concluded on 2 August. Our Medical Team supported over 2,100 evacuees and treated over 400 patients during the NEO operation.

NAVCEC Operational Support Detachment BRAVO is one of the assigned Navy Reserve units specializing in Contingency Response, Humanitarian Assistance and Disaster Relief. ⚓

—Story by LT Mark Ingram, MC, USNR and CDR Jim Linder, USNR. RAF Akrotiri, Cyprus

Naval Hospital Jacksonville Deploys Staff Members to Kuwait

Naval Hospital Jacksonville saw six staff members off to expeditionary medical facility (EMF) Kuwait. This was followed by the return of 16 medical personnel from a 6-month deployment to EMF Kuwait.

Surgeon LT William Lechuga was upbeat about the deployment. “We’re going to have an opportunity to do some good out there,” he said. “I hope to be able to help out and do what I can to get people fixed up so they can do what they need to do.” Lechuga said he expects to mainly provide routine surgical services, such as appendectomies, gall bladder operations, etc. at the EMF. But he added they will likely see some trauma, coming from the war zone. ⚓

—Story by Loren Barnes, Naval Hospital Jacksonville Public Affairs.



NHCC Medical Staff Members to Deploy to Iraq, Kuwait

Naval Hospital Corpus Christi (NHCC) dispatched 20 medical personnel to Iraq on 13 August and 4 more to Kuwait 4 days later. This brings the total number of staff from the Branch Health Clinics deployed to 69. NHCC’s total military staff is 338.

“Over the course of July and August, we’ve deployed an additional 44 of our heroes for critical global war on terror missions, joining the 25 already overseas,” said CAPT James P. Rice, MC, CO of NHCC. “All are doing an outstanding job. I speak for all of us when I say just how very badly we miss them and look forward to their return!”

CAPT Rice also emphasized the importance of both military and civilians, who have not deployed. “Without medical care and support for our beneficiaries and their families, our mission would not be accomplished.” ⚓

—Story by Bill Love, Naval Hospital Corpus Christi Public Affairs Office



Corpsmen Earn Respect and the Title “Doc”

They stay in the field, eat meals ready to eat, sleep on the ground, wake up before dawn, and wear the eagle, globe, and anchor. They’re corpsmen.

When artillery batteries from Marine bases in California, North Carolina, and Hawaii deployed to Okinawa on the Marine Corps’ Unit Deployment Program, they took all essential equipment and personnel. That, of course, includes those vital corpsmen, the men tasked with providing medical care to Marines wherever duty calls them, no matter how undesirable or grave the conditions.

Be it the battlefields of Iraq and Afghanistan, or the less treacherous training area of East Fuji Maneuver Area on mainland Japan, field corpsmen carry on a proud naval tradition of blurring the distinction between blue and green.

But it’s not easy being green, and the rapport between Marines and corpsmen isn’t automatic. Maybe that’s why most Navy “docs” go above and beyond their duties to show their devotion to the Marines under their care.

“I try to do more than just what a corpsman is supposed to do,” said HN Adam R. Crandall, a corpsman with M Battery, 3rd Battalion, 11th Marine Regiment - one of three batteries that are attached to 3rd Battalion, 12th Marines, 3rd Marine Division, for the artillery relocation exercise in Fuji. “I’ll get out there and help them do their job. I want to improve the lives of the Marines I’m working with in any way possible, even if it just lending someone my poncho or sitting down and talking with them.”



HM3 Jason W. Andrews (left) checks up on Marines on the gun line. Andrews, a corpsman with M Battery, 3rd Battalion, 11th Marine Regiment, 1st Marine Division, has been with the unit for more than 3 years. Photo by PFC Corey A. Blodgett, USMC, Marine Corps Base, Camp Butler, Okinawa

Corpsmen have served alongside Marines for more than 200 years, keeping them healthy, combat ready and, in many instances, alive. But the bond between Marine and corpsmen goes further than necessity.

“The relationship between Marines and docs is probably better than a Marine to a Marine,” said PFC Daniel R. Grigsby, a field artillery cannoneer with M Battery. “I think the docs are seen more as a friend. It’s not like a fellow Marine that is ‘This is my colleague.’ With the doc it’s, ‘This is the doc. He’s a cool guy.’”

But simply being “a cool guy” is not enough to earn Marines’ trust and respect, according to HM3 Jason W. Andrews.

“All the Marines know me, trust me, and will come to me for anything,” said Andrews. “But that trust comes with time. We have to prove that we’re not going to lie to them, and that we’ll treat them the way they deserve. If we treat the Marines well, they treat us well, but if we lie to them or don’t hold our weight, we become outcasts.”

Corpsmen also earn respect by performing everyday Marine Corps duties in the field, such as digging trenches and providing security at night. “The docs are treated as Marines whether they like it or not,” said LCPL Anthony M. Leone. “But it’s like they’re Marines anyway. We’re close to each other, if anyone has a problem they can take it to the docs.”

“Corpsmen, when attached to Marine units, aren’t considered Navy, they’re Marines.” Leone said. 

—Story by PFC Corey A. Blodgett, USMC, Marine Corps Base, Camp Butler, Okinawa.

Corpsman Receives Navy Commendation for Courage Under Fire

During a ceremony held at Marine Corps Base Hawaii on 26 May, III Marine Expeditionary Force Deputy Commanding General, BGEN Mastin M. Robeson, presented a hospital corpsman from 1st Battalion, 3rd Marine

Regiment with the Navy and Marine Corps Commendation Medal with “V” Device. The award was for acts or service involving direct participation in combat operations. HM3 Robert John Paul Hinckley, Combined Anti-Armor Team II, Weapons Company, received the award for his actions under fire during 1st Battalion, 3rd Marines’ deployment to Afghanistan where the unit was supporting Operation Enduring Freedom.

The Finley, WA, native said he remembers what happened 25 Jan when a convoy in which he and several other Marines were riding left Camp Blessing and headed east along Pech River Road. Hinckley, the only hospital corpsman along for the ride, was a passenger in one of the vehicles positioned in the rear of the convoy.

“We were riding through an area called ‘IED cliff,’ when one of the vehicles in front of me got hit by an IED [improvised explosive device],” said the 22-year-old. “The explosion caused the vehicle to flip upside down.” After the explosion, Hinckley said he was quick to respond. “I was the first one out of the vehicle. I ran up to the ‘high back’ [humvee] to assess the casualties,” explained Hinckley.

He said he immediately realized that the driver was unharmed during the blast, but the passenger, LCPL Billy D. Brixey, from 1st Battalion, 3rd Marines, was trapped in the vehicle and severely injured.

“I noticed he was hurt pretty bad,” said Hinckley, remembering his first reaction after seeing the trapped Brixey. He said his legs, arms, and some of his fingers were broken. “Other Marines witnessed Hinckley’s actions that day. ‘I saw him run up to LCPL Brixey and start taking care of him,’ said LCPL Kyle L. Koons, missileman, Weapons Company. “He was doing his job.” About the time Hinckley arrived at the destroyed vehicle, the ambush came into full effect. Insurgents started firing at the halted convoy with machine guns and rocket-propelled grenades. Koons said he saw Hinckley position himself in front of the fallen Brixey, to shield him from enemy fire. “I looked around and saw rounds bouncing off the ground and the vehicle all around us,” recalled Hinckley, who said he knew he needed to get Brixey out of the vehicle as soon as possible. “They were trying to shoot us because they saw a wounded Marine and a corpsman.”

After getting Brixey safely out of the vehicle, Hinckley was able to stabilize him, and applied as many splints to Brixey’s broken bones as he could, all the while protecting him from a barrage of enemy fire. “My first instinct was to get him some cover, said Hinckley. “I needed to save this Marine’s life.”

The firefight ended when artillery support was called in on the enemy’s position up in the mountains. Badly wound-



HM3 Robert John Paul Hinckley, poses with the recently awarded Commendation Medal. Photo by LCPL Ryan Trevino

ed and in need of immediate care, Brixey was rushed to a helicopter waiting to transport him to the closest hospital for treatment. He later died of his wounds received during the explosion, while on his way to a hospital in Germany. According to the award citation, Hinckley, with complete disregard for his own safety, coordinated the delicate removal of the Marine from the wreckage under intense enemy fire for 30 minutes.

The deployment to Afghanistan was Hinckley's second with 1st Battalion, 3rd Marines. He was also with the unit during the initial assault on Fallujah in support of Operation Iraqi Freedom.

This was Hinckley's first award of any kind, and according to the sea-service veteran, it was completely unexpected—just like the day he found himself under enemy fire, treating a wounded Marine. "At one instance, I thought, 'Wow, I never thought I would find myself here.'" 

—Story by LCPL Ryan Trevino, Marine Corps Base, HI.

Deployed Doc Mends Bodies and Minds in Iraq

HN Samuel L. Blanco is a healer. The hospital corpsman geared up in layers of body armor has a bag of tricks he carries that's not just healing the bumps and bruises, scrapes and cuts, but also relations and trust between Americans and local Iraqis.

Blanco provided healthcare for dozens of Iraqis during a combat patrol with 3rd Battalion, 2nd Marine Regiment, through an Iraqi village here 23 September. "From an American view, it gives us a sense of pride to know that Iraqis would come to us," said Blanco.

He said less than 2 months ago, Iraqis in this area west of Fallujah were hesitant to even speak to him or the Marines when they first started serving under Regimental Combat Team 5. The mood is changing though. Now, instead of leery stares, parents are bringing their children forward to get a once-over from "Doc" Blanco.



HN Samuel L. Blanco, calms and bandages an Iraqi child during a combat patrol in Husayba, Iraq 23 September. LCPL Ray Lewis, USMC, 1st Marine Division



HN Samuel L. Blanco and MSGT Donald M. Iskerka pause during a patrol through a neighborhood east of Husayba, Iraq. LCPL Ray Lewis, USMC, 1st Marine Division

"When they get a serious problem they can come to us," said LCPL Paul J. Burns. "They're starting to get close to us and recognizing the doc." He added "the locals could pick out the resident medical expert by his calm persona."

"Soon as they found out that I was a doc everybody was 'fix me, fix me, bandage,'" Blanco said.

He doesn't mind it. He said he enjoys contact with the Iraqis.

"Doc's not afraid to get hands-on with the residents," said LCPL Liam E. Izar. "It's great having him around. He helps us focus on doing our job," he said.

One time he helped divert a health concern to him while Marines continued conducting combat operations. It was a scary situation for the child in need, but one that left him feeling better and his parents a little more trusting of Marines.

"A guy brought his kid to me to fix," Blanco said. "He had a bruise with a laceration. The kid was crying and scared to death of me. I fixed him up and he was smiling when we left." Blanco cherishes those moments. He said he's doing what he signed up to do. He's helping people, no matter their nationality or situation. He's healing bodies and minds. "It's a humbling experience when people depend on you out here," Blanco said. "It's very rewarding."

Blanco said that helping Iraqis is bigger than himself. It's that one act of common human concern that's bringing Americans and Iraqis closer. "It's good to know that we're doing good things for people," he said. "It puts a good feeling in your heart." 

—Story by LCPL Ray Lewis, 1st Marine Division, Husayba, Iraq.



Subic Bay, Philippines. LT Brent Driskell, medical officer assigned to Marine Wing Support Squadron One Seven Two (MWSS-172), provides a medical evaluation to a local resident at the San Juan Elementary School, San Antonio, Zamables, during the medical/dental civic action project Exercise Talon Vision and Amphibious Landing Exercise (PHIBLEX). October 2006. Photo by SSGT Ricardo Morales, USMC



Sigonella, Sicily. HM3 Michael Duer performs a lung exam on LTJG Matthew McCullough. McCullough is assigned to Patrol Squadron Sixteen, which is forward deployed in support of maritime patrol operations and the global war on terrorism. September 2006. Photo by MCS1 Mark Anthony Geil



Gulf of Oman. CDR Thomas Davis (right), and HMCS Tina Stanco, conduct an operation aboard the aircraft carrier USS *Enterprise* (CVN-65). *Enterprise* and embarked Carrier Air Wing One (CVW-1) are currently on a scheduled 6-month deployment in support of Maritime Security Operations and the global war on terrorism. October 2006. Photo by MCSN Dale Patrick B. Frost



Indian Ocean. LCDR Gordon Wisbach, Fleet Surgical Team 5's lead surgeon, performs surgery aboard the amphibious assault ship USS *Boxer* (LHD-4). *Boxer* is operating from San Diego as the Navy's only forward-deployed amphibious task force. October 2006. Photo by MCSN Paul Polach



Hindi, Kenya. HM1 Brian Dessel stationed at the Medical Center, Bahrain, examines a boy's leg as part of a Medical Civic Action Program (MEDCAP) in Hindi, Kenya, outside of Lamu. Kenyan navy and U.S. military medical personnel treated more than 1,500 local citizens in Hindi, ending their 6-day trip treating more than 4,600 people in Kenya. September 2006. Photo by MCSA Eric A. Clement



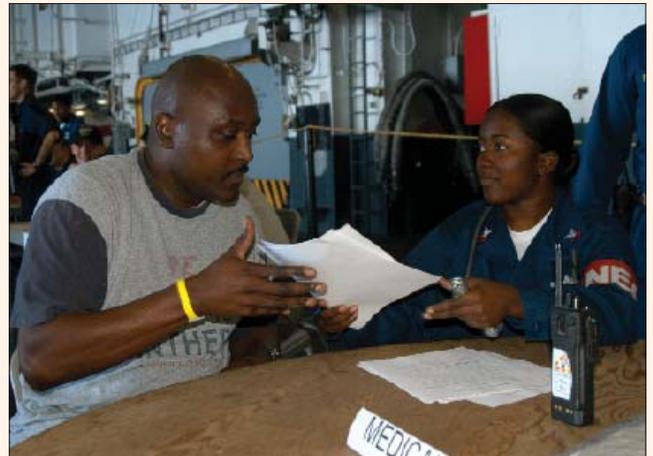
Nginyang, Kenya. CDR Dr. Warren Gilbert (left), examines a patient with a mock head injury during field training, part of exercise Natural Fire at Camp Lonestar. Natural Fire is the largest combined exercise between Eastern African community nations and the United States, and includes medical, veterinary, and engineering civic affairs programs. August 2006. Photo by MCS2 Roger S. Duncan



Pacific Ocean. LCDR Chris Pace, DC, performs a jaw tumor biopsy in the ship's medical department aboard the nuclear powered aircraft carrier USS *Nimitz* (CVN-68). *Nimitz* is currently underway off the coast of Southern California conducting sea trials after successfully completing a 6-month Planned Incremental Availability (PIA) period. September 2006. Photo by MCSN Emily Stroia



Arabian Sea. LT Matthew Conquest prepares to perform a pulp test on a patient in the Dental department aboard USS *Enterprise* (CVN-65). September 2006. Photo by MCSN Nowie Solis



Mediterranean Sea. HM2 Tiffany Brown helps Storekeeper 1st Class Joe Williams, an evacuee role player aboard the multi-purpose amphibious assault ship USS *Wasp* (LHD-1), get checked into the medical department during a Non-Combatant Evacuation Operation (NEO) drill. September 2006. Photo by MCSN Robbie Stirrup

Pensacola Anesthesiologist Provides Specialty Training For 28 Docs at Course in Yemen

Naval Hospital Pensacola anesthesiologist, Dr. Craig Bonnema, currently the Command Surgeon of the Combined Joint Task Force/Horn-of-Africa (CJTF-HOA) in Djibouti, and Dr. Yahia Huraibi, Chief Anesthesiologist at the al-Thawra Hospital in Sana'a, concluded a 3-day specialty training refresher course at the Presidential Hospital in Marib, Yemen, during the last days of August.

The United States Agency for International Development (USAID) and the Ministry of Public Health and Population worked in cooperation to organize this important teaching conference, the first ever at the Marib Presidential Hospital.



Drs. Rinaldo, Huraibi, Bonnema, and Muftah with trainees at the Presidential Hospital. Photo courtesy of author

Twenty-eight practitioners of anesthesiology from the five Governorates of Marib, Shabwa, Sa'dah, al-Jawf, and Amran attended the conference. The objective of the training was to improve the quality of healthcare services in some of Yemen's most underserved regions.

Back at Camp Lemonnier in Djibouti on 2 September, Bonnema said that he had "presented some more advanced lectures to the medical staff at one of the larger hospitals in the capital city of Sana'a. Everyone was very pleased with how well it went, including the U.S. Ambassador and officials from the Yemeni government."

The conference focused on a highly specialized area--anesthesiology--which is critical to all patients undergoing surgical procedures in the Governates, whether resulting from disease or injuries. At the end of the workshop the participants expressed their gratitude to both physicians for their outstanding academic presentations. The mission was good, continued Bonnema, demonstrating the "soft power" of U.S. military medicine, "I was there more as a physician than a naval officer. We went to a very wild and destitute area of Yemen that's a focus of American efforts to improve medical care at the most basic level."

Dr. Abdorabo Muftah, Principal Health Officer in Marib Governorate, expressed his gratitude for the ongoing, strong and successful United States support to the Yemeni health-care system.

Dr. Bonnema affirmed his thanks for Yemen's hospitality during his visit to Marib. Dr. Yahia Huraibi reaffirmed that Yemeni healthcare providers wish to continue seeking exposure to U.S. medical scientists and researchers.

USAID and other representatives expressed their commitment to bringing more specialists to teaching conferences in these five governorates. 

—Story from Naval Hospital Pensacola Public Affairs Office.

Saving Lives One Marine at a Time

"Help, help I have been hit, someone please help me," said one Marine as he played the role of a casualty. Sound effects of small arms fire and explosions filled the ears of all who were in the simulation.

Marines attending combat lifesavers course here, rushed through trees and bushes to perform medical treatment to those with simulated injuries. The injured were triaged and the combat lifesavers performed first aid to stabilize the victims and moved them to a secure location.

CPL Eric Myers, a communications technician, carried a Marine from the woods using one of the many carries taught during the course.

HM3 Martin A. Shepherd yelled, "Get down! Enemy fire! Take cover! Take cover!" Sounds got louder and louder as Myers tried to get his fellow Marine to a more secure location. Myers carried the Marine to an open field where he started performing advanced first aid on his comrade while other combat lifesavers emerged from the woods with another victim.

They set up a triage point and prioritized the victims based on who needed to be evacuated first. "I wanted to make it as real as I possibly could," said Shepherd. "The only way for the Marines to know what is going to happen out in the desert is for them to do it in a lifelike situation."

Patients all over the landing zone were screaming in pain. Combat lifesavers moved among the casualties checking their vital signs as they waited for a helicopter to evacuate the injured. Myers checked two victims as the helicopters approached.

"I put fake wounds on their arms, legs, and all over to make it look like a real injury," Shepherd said. "I have the tools to make these Marines think that these people are really hurt. The more realistic it is the more the combat lifesavers get into it and try their hardest to fix their brother and sister Marines."

Shepherd told the Marines the helicopter had landed and they had 15 seconds to get the first injured Marine there. Myers put a critically injured Marine over his shoulder and ran to the helicopter. He put him in and returned back to assist other Marines until more help came.

“This is the first time in a year and a half that I have done this type of practical application,” Shepherd said. “I want it to be real good. These Marines will have to deal with many different types of injuries at one time. There will be more injured than there are lifesavers on the scene. This isn’t going to be easy for them. If it was easy, then they wouldn’t learn anything from it.”

“For the first time running through a situation like this, they did really well,” Shepherd said. “Corpsmen go through training all the time to perfect it. They had a 4-day course and did everything they could to keep their fellow Marines alive. When it comes down to it, that is all you can do. Do your best and get more help as fast as possible. I am really proud of this group of Marines. They did more than I could expect of them.”

—Story by PFC Joseph D. Day, 2nd Marine Division, Camp Lejuene, NC.

Mojave Viper Medical Training from Injury to Evacuation

Injuries in war are an oft-highlighted subject in the news and here at the Combat Center it is the job of corpsmen on the staff of the Tactical Training Exercise Control Group (TTECG) to ensure that deploying Marines and corpsmen receive the best possible medical training.

The TTECG corpsmen evaluate, train, and test the corpsmen and Marine combat lifesavers through a series of exercises that end in the Mojave Viper final exercise where the unit must care for the simulated wounded from the point-of-injury to the necessary level of follow-on care.

“We realize that these Marines and corpsmen are going to war so we try to make the training as realistic as possible,” said HM1 Temitope Ayeni, head medical instructor at TTECG.

Nearly all the TTECG staff corpsmen here have personally experienced lifesaving during multiple deployments to Iraq. Exercise Mojave Viper’s medical training is designed to reinforce life-preserving actions by focusing on the basics and then gradually increasing the seriousness and stress of the medical care for the simulated patients.

Training is divided into sections with each successive event requiring more sophisticated care procedures and additional evacuation requirements.

Classroom: casualty assessment, evacuation, and triage.

Live-fire training: simulated casualties are assigned, and corpsmen must properly triage, care for, and evacuate them from the point-of-injury to the unit’s casualty collection point.

Motorized operations course: requires medical personnel to move the simulated casualties from the point-of-injury through the casualty collection point and then to a landing zone for a simulated helicopter evacuation.

Deliberate assault course: a company (reinforced)-sized live-fire attack, the corpsmen must evacuate along the route to the battalion aid station via a helicopter airlift.

Urban warfare training center: urban skills range from tank-infantry integration to assaults on urban targets. Dubbed “lane-training” because each day focuses on different skill sets, each of the lanes provides for medical training and assessment.

“The participants don’t know what is inside when they come down our lane,” said Ayeni. “Once inside they quickly realize there are simulated injuries and they must use their Improved First Aid Kit to take the necessary steps to save lives. They have 5-7 minutes to complete all the necessary tasks involved in casualty assessment, treatment, triage, and evacuation. It requires quick thinking and good analysis of the injuries.”

“Before they come here, Marines can’t open up their IFAKs for training; they are issued one and that is it,” said HM2 Kevin Garcia. “We provide them with kits they can use to give the first aid required. Without this training, the gear in their IFAK would be unfamiliar.” Garcia deployed twice to OIF, first with 1st Battalion, 6th Marines and then with a surgical company located at Al Asad.

In another area of Range 215, HM2 Khan Webb trains other units for casualty evacuation drills.

“We are assessing how good their training was at home and prepping them for the harder things to come,” said HM2 Kahn Webb. “We try to teach Marines not to rely on the corpsman,” he said. “A squad or patrol might not always have one and they have to take care of each other.”

—Story by CAPT Chad Walton, Public affairs officer, Tactical Training Exercise Control Group.

“Red Lions” Hone Lifesaving Skills

“Exercise. Exercise. Exercise.”

“Mayday! Mayday! Mayday! Red Lion 98 and 99 in midair collision over West Field with 48 total souls! Losing control of A/C!”



LCPL Christopher M. Garrett, Heavy Helicopter Squadron 363, applies pressure to a Marine with an open wound to stop the flow of blood. Photo by LCPL Edward C. deBree, Marine Corps Base, HI.

Those were the words that blasted over the radio call received by the air traffic control tower here at the Marine Corps Air Facility HI.

Those words all set the tone for Marines and sailors assigned to Marine Heavy Helicopter Squadron 363 who were participating in a mass casualty/mishap drill at West Field. The drill served to prepare HMH-363 squadron members for their upcoming deployment to Iraq.

“We had three goals that we wanted to achieve during this drill,” said flight surgeon LT Peter Lombardo. “We wanted the corpsmen and combat lifesavers to practice combat casualty care. We wanted the squadron to practice ready room mishaps, and we wanted the MAG aid station to conduct a mass casualty drill—all of which we accomplished.”

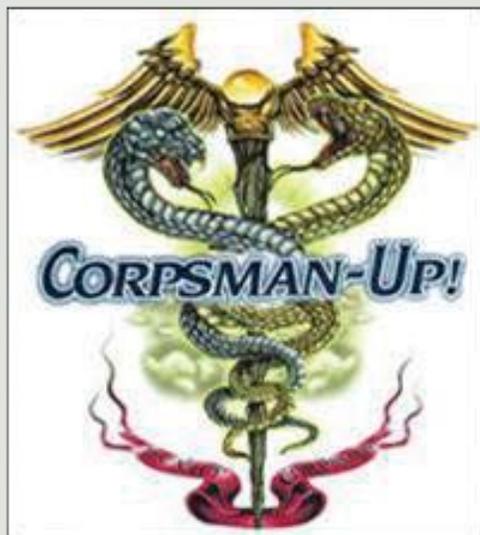
Aircraft Rescue Firefighters arrived on scene to extinguish fires on the two aircraft and to help transport crash victims to a safe area where they could be examined and the wounded treated.

Our main priority was to find the people who needed the most help,” explained SSGT William B. McCormick, section leader, Section Two, ARFF.

“The combat lifesavers performed admirably,” said Lombardo. “This training will prepare them well for any mishap that might occur. The participants attended classroom training, which in itself can be challenging, training to learn how to treat patients,” he added. “To get out there and actually apply what you have learned is invaluable,” Lombardo continued. “They’ve proven that they can treat any major combat injury.”

Combat lifesavers are trained to treat wounded personnel in a combat situation until a corpsman is available to tend to the service member’s wounds. “We need to expand combat lifesavers in the unit,” said Lombardo. “It’s good training for anybody to have. We need to train as many Marine combat lifesavers as we can.”

—Story by LCPL Edward C. deBree, Marine Corps Base, Hawaii.



HN Charles O. Sare, 23, of Hemet, CA, died 23 October from injuries suffered from enemy action while

conducting combat operations in Al Anbar Province, Iraq. Sare was assigned to Naval Ambulatory Care Center, Port Hueneme, CA, and was currently serving with Multi-National Corps.

HM Chadwick T. Kenyon, 20, of Tucson, AZ, died 20 August from injuries suffered when



his vehicle was struck by an IED in Al Anbar Province. Kenyon was assigned to the 3rd Light Armored Reconnaissance Battalion, 1st Marine Division, I Marine Expeditionary Force, Twentynine Palms, CA.

HM2 Christopher G. Walsh, 30, of St. Louis, MO, died 4 September from injuries suffered while his unit was conducting combat operation in Al Anbar Province, Iraq. Walsh was assigned to the Navy Reserve 3rd Battalion, 24th Regiment, 4th Marine Division, Bridgetown, MO, and was currently serving with Multi-National Corps.



NEPMU-7 Disestablishes After 50 Years of Public Health Support

*CDR David M. Claborn, MSC, USN
LTJG John McAfee, MSC, USNR*

The Navy Environmental Preventive Medicine Unit-7 (NEPMU-7), Sigonella, Italy, was disestablished on 30 September 2006. The following retrospective captures the essence of the many contributions to the field of public health made by NEPMU-7 over 50 years.



The year was 1956 and the Europe-Africa region was significantly different than it is today. The “Iron Curtain” described by Winston Churchill had crashed down between Eastern and Western Europe, fomenting a Cold War that divided the world into capitalist and socialist camps. Africa was just beginning to emerge from an era of European colonialism and would not be free of European governance for another 14 years. Smallpox was still an important health threat in much of Africa and the Middle East, resulting in as many as 200,000 cases each year.

That year also marked the establishment of a small unit of U.S. Navy preventive medicine specialists in Naples, Italy, commissioned to provide public health support to American military assets throughout the European theater of operations, Africa, and Southwest Asia.

This year (2006) marks the 50th anniversary and sadly, the closure of that same unit. During the last half-century, NEPMU-7 has witnessed and played a key role in momentous changes that have helped re-shape the modern world. For instance, the Cold War has been replaced by a much hotter global war on terrorism. Africa has emerged from colonialism only to wrestle with stagnant economies, unstable governments, and rampant disease, including the new and devastating pandemic of HIV/AIDS. Yet, at the same time, smallpox has been eradicated by a thorough immunization program. The recent history of Europe, Africa, and

Southwest Asia is reflected in the birth and development of NEPMU-7.

Initially, NEPMU-7 consisted of approximately 15 personnel, including one locally-hired Italian national who served as translator and command secretary. The officer staff consisted of preventive medicine physicians, environmental health officers, and entomologists. Through the years, microbiologists and industrial hygienists were added, as well as Navy healthcare administrators. Very recently, a Plans, Operations, and Medical Intelligence (POMI) officer was added. At times, the staff was augmented by an Air Force veterinarian. The enlisted staff typically consists of preventive medicine and laboratory technicians as well as general duty hospital corpsman. The staff has rarely exceeded 35 in number during the entire history.

The unit provides public health support to the fleet and shore facilities in Europe, Africa, the Middle East, and Southwest Asia. Originally located in Naples, Italy, NEPMU-7 moved to Naval Air Station Sigonella, Sicily in the 1990s. Support included medical advice on immunizations and chemoprophylaxis, disease outbreak investigations, water quality assessments, agricultural quarantine inspections, pest control, port health assessments, mass immunizations, and many other public health services. As the capabilities of NEPMU-7 became more widely known, the unit responded to a wide variety of humanitarian missions, disasters, and disease outbreaks. In 1968, for instance, NEPMU-7 provided expert analysis and guidance for outbreaks of meningococcal meningitis in Palermo and rampant canine rabies in Naples. In northern Africa, they addressed meningitis and malaria outbreaks in Morocco, as well as floods in Tunisia and the deterioration of municipal water systems in Ethiopia. Table (2) is a partial listing of humanitarian assistance and disaster relief operations supported by the unit.

Despite the extensive support of humanitarian and disaster relief missions, the primary mission always remained public health support for the Mediterranean based 6th Fleet, Fleet Marine Force, and fleet support activities throughout the Unit AOR. Since 1990 this support has often taken the form of large team deployments to provide operational

Table 1: Humanitarian Support Operations by NEPMU-7 (1968-2005). A Partial Listing

| YEAR | ISSUE | PLACE |
|------|-------------------------------------|--------------------------|
| 1968 | Canine rabies | Naples, Italy |
| 1969 | Flood relief | Tunisia |
| 1969 | Deteriorated municipal water supply | Asmara, Ethiopia |
| 1973 | Cholera outbreak | Naples, Italy |
| 1975 | Operation NIMBUS | Suez Canal Mine clearing |
| 1985 | Cholera outbreak | Somalia |
| 1991 | Diarrheal outbreak | Hurgada, Egypt |
| 1991 | Operation PROVIDE COMFORT | Kurdish Northern Iraq |
| 1992 | Operation PROVIDE RELIEF | Somalia |
| 1992 | Operation RESTORE HOPE | Somalia |
| 1993 | Operation PROVIDE PROMISE | Bosnia |
| 1993 | Operation PROVIDE HOPE IV | Kazakhstan |
| 2005 | Operation LIFELINE | Pakistan |

Table 2: Unit Awards for NEPMU-7

| AWARD | MERIT START | MERIT END | CAMPAIGN |
|-------------------------------------|-------------|-------------|---|
| Meritorious Unit Commendation | 28 Aug 1973 | 25 Sep 1973 | Outstanding performance of duty during cholera epidemic in Naples, Italy |
| Navy Unit Commendation | 2 Aug 1990 | 28 Feb 1991 | In support of Operations DESERT SHIELD and DESERT STORM |
| Joint Meritorious Unit Commendation | 23 Jul 1994 | 7 Oct 1994 | In support of the Joint Task Force, Operation SUPPORT HOPE |
| Meritorious Unit Commendation | 1 Jul 1994 | 1 Apr 1997 | In support of operational forces in the European, African, and Southwest Asian Theaters |



NEPMU7 team members aiding with typhoid immunization program during a 1970 deployment to Ethiopia. Photo from NEPMU7 Archives

preventive medicine and environmental health expertise for the Marine Corps and Army units in the Middle East and Southwest Asia.

NEPMU-7 deployable preventive medicine assets supported Operations Desert Shield and Desert Storm in Saudi Arabia and Kuwait in 1990-91 initially using the Preventive Medicine Mobile Medical Augmentation Response Team (PM-MMART) .

The PM-MMARTs evolved into the current Forward Deployed Preventive Medicine Unit (FDPMU) in the early 2000s. Since then FDPMU platforms, including NEPMU-7's, have deployed extensively throughout Operation Iraqi Freedom I, II, and III primarily in support of U.S. and coalition ground forces in Iraq. The new FDPMUs significantly expanded operational force health protection support capabilities beyond the traditional preventive medicine and environmental health focus on disease outbreak investigations, environmental health threat assessment, food and water quality, hygiene, and disease vector control.

The FDPMUs now use state-of-the-art scientific analytical instruments to detect environmental contaminants in the form of toxic chemicals and toxic materials, as well as provide deployable confirmation of chemical and biological warfare agents.

Since 2002, an FDPMU composed primarily of NEPMU-7 team members has deployed three times to Iraq.

Providing support to victims of natural disasters is equally important aspect of the FDPMU mission. For example, a mission-specific preventive medicine team provided humanitarian support during earthquake relief efforts to Pakistan in 2005. In retrospect, NEPMU-7 has provided preventive medicine teams and individual augmentees to support operations in Iraq, Kuwait, the Horn of Africa, the Gulf of Guinea, Liberia, Somalia, Egypt, Croa-

tia, Kazakhstan, Rwanda, Uganda, Zaire, and many other countries during its 50 years. (See table 1)

In 2005, the decision was made to close NEPMU-7 as part of the current and ongoing U.S. military transformation in Europe efforts. Unit billets and some personnel will be transferred to sister units in the continental United States, primarily NEPMU-2 in Norfolk, VA.

Overall, NEPMU-7 has enjoyed a rich 50-year history, responding to many public health challenges throughout its vast area of responsibility. After the fall of the Iron Curtain, NEPMU-7 began making country visits to members of the former Warsaw Pact. NEPMU-7 often provided the public health support required for exercises held in former Eastern European communist countries. In Africa, post-colonial adjustments, internecine conflicts, and natural disasters required rapid humanitarian responses. NEPMU-7 met those challenges head-on and was often recognized for its efforts.

The changing aspects of disease transmission, including the resurgence of malaria, the elimination of smallpox and the emergence of HIV/AIDS, have all stimulated the development of regional expertise and local response capabilities for public health support. With the disestablishment of NEPMU-7, greater efforts will be required to develop and maintain area-specific expertise and field capabilities. However, NEPMU-2 stands ready to assume responsibility and support for the NEPMU-7 AOR. 

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Camp Iwo Jima, Kuwait. HM2 Willy changing the filter in a MINIVOL, a device used to sample air quality, 2003. Photo by HM1 Dustin Menezes

Changing the Paradigm of Care: A Patient Centered System

*LCDR Steven J Escobar, MC, USN
LT Delia Edson, NC, USN
LT Julie Burson, NC, USN*

Recent literature is replete with stories of patient dissatisfaction in today's health care system to include efficiency, access to care, and quality of care. Increasingly, due to budgetary cutbacks and manning issues, military treatment facilities (MTFs) are being asked to be more productive and efficient while at the same time provide high quality, timely care for our patients. The current global war on terrorism has left many MTFs with fewer healthcare professionals to care for the same patient population as that of peacetime. Providers are continually encouraged to increase the daily number of patients seen as well as the relative value units (RVUs) per visit. This increase in workload without a change in practice may lead to both access to care and patient safety issues, which in turn leads to decreased patient satisfaction.

In 1999, The Institute of Medicine published a report on medical errors and their consequences entitled "To Err is Human."⁽¹⁾ The Institute's follow up report, "Crossing the Quality Chasm: A New Health System for the 21st Century," envisions closing the gap between what is known to be good quality care and what actually occurs in daily practice.⁽²⁾ The report emphasizes that marginal reform is inadequate to fix the problem and discusses six "aims for improvement" to optimize the healthcare system: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. A paradigm shift to a patient-centered care environment provides a framework for needed improvements and supports the aims of the Institute of Medicine.

Patient-centered care deviates from the "traditional" approach by enabling patients to become active participants in their own care and receive services designed to focus on their individual needs and preferences. The "traditional" model of healthcare is disease-centered and relies primarily on the healthcare provider to make treatment decisions. Evidence-based reviews have demonstrated patient-centered practice improves health status and increases the efficiency of care by reducing diagnostic tests and referrals and impacts positively on patient satisfaction,⁽³⁾ (Cochrane Database of Systematic Reviews). Many large healthcare organizations, including the Joint Commission on Accreditation of Healthcare Organizations and the Agency for Healthcare Research and Quality, are proponents of this strategy. In order to fully implement a truly patient-centered environment, reorganization of the basic infrastructure, to include collaboration of patients and their families, as well as planners, administrators, providers of care, and other staff members, is required. This reorganization is in addition to the basic philosophical change in the physician-patient relationship.

In trying to better meet the needs of our beneficiaries at Naval Hospital Guam, we have adopted a patient-centered

approach to care in our overseas internal medicine clinic. The clinic functions both as a primary care clinic as well as a medical sub-specialty referral clinic and is staffed with general internists. A full spectrum of outpatient and inpatient services is offered. There is a large retiree population and greater than 90 percent of the clinic's enrolled patients are Medicare eligible. The nearest referral center is located 3,800 miles away by air.

Once the decision was made to adopt patient-centered care, it became apparent the clinic infrastructure required remodeling. A patient preference questionnaire was mailed to all enrolled patients. An automated phone line was installed with options for medication renewals, appointment scheduling, and direct communication with the clinic nurse and front desk personnel. Patient flow and processing from check-in to the exam room was streamlined for less patient movement. The appointment booking clerk was moved from a "central" appointments remote site to an office located within the clinic itself. The number of exam rooms was increased, and a treatment room for invasive procedures and intravenous infusions/transfusions was added. After the above changes were made, an open access scheduling template was created.

Open access allows patients to be seen the same day of requesting an appointment, regardless of the reason for the visit. There is no distinction between urgent or routine office visits. The idea is to complete "today's work today." Thus the daily patient load varies depending upon demand. Patients are preferably scheduled with their assigned physician, which reduces future demand by maximizing the current visit. The idea of open access was founded by Murray and colleagues. Murray's 2000 article entitled "Same-Day Appointments: Exploding the Access Paradigm" discusses how to implement advanced access booking.⁽⁴⁾ "Innovations in Access to Care: A Patient-Centered Approach" discusses three organizing principles that aid the user in integrating the concept and philosophy of advanced access.⁽⁵⁾

After 7 months of implementing patient-centered care, patients were again surveyed and the data collated. Results show that outpatient encounters have increased by 37 percent without a change in clinic operating hours. Appointment wait times have decreased from 3 weeks to 24 hours. The number of cancellations has remained steady at 11 percent, but "no shows" have decreased from 9 percent to 1 percent and walk-ins from 8 percent to <1 percent. The number of procedures performed in clinic has increased more than threefold. Many patients who had been routinely diverted to the emergency department in the past were able to be accommodated in the clinic as a result of both open appointments and enhanced telephone triage. Several "frequent flyers" requiring hospitalization every several weeks were able to be treated in the outpatient setting (with intravenous infusions and/or transfusions), thus saving over \$36,000 per month as well as negating the inconvenience of hospitalization. Most importantly, patient satisfaction increased by 25 percent.

The largest daily barrier encountered with open access appointment was found to be in obtaining medical records prior to office visits. Secondary records were started to help ensure

continuity for patients. Also, the number of exam rooms available and space in the waiting room are now deficient, and plans for remodeling the clinic waiting area and acquiring more patient exam rooms are in place.

The above approach to patient centered care demonstrates a marked paradigm shift from a traditional military primary care clinic. The increased efficiency and satisfaction of the clinic, as demonstrated by the increase in patient encounters and patient satisfaction without a concomitant change in clinic operating hours, demonstrates how change implemented at the clinic level can have highly effective outcomes. The ideology of patient-centered care is a concept that can be implemented Navy-wide but the specifics of how each medical center, hospital, or clinic changes to meet the needs of their unique populations must be done at the local level.

Improving clinic encounters, access to care, and perceptions are initial steps in a patient-centered care approach. Since no clinic can function optimally without other services, the concept of patient-centeredness must branch out from the clinic to all aspects of the healthcare encounter. As the patient navigates through the healthcare system, areas such as facilities, ancillary services, and inpatient services should be involved in discussions on how to make the patient the center of focus.

In summary, our clinic is now able to more effectively provide comprehensive and evidence-based management

for our patient's chronic diseases through a patient-centered approach to care. We hope this article will stimulate other healthcare providers to investigate how a patient-centered system may present a solution to safety, effectiveness, timeliness, efficiency, and equity in the delivery of healthcare.

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USNS Comfort's MTF Skipper

When the Navy's two hospital ships, USNS Mercy (T-AH 19) and USNS Comfort (T-AH 20), came on line in the mid 1980s, the Cold War was still very much alive, and the two vessels were an integral part of a medical strategy to help defend Europe against a massive Soviet offensive in central Europe.

Since the collapse of the Soviet Union, both ships have assumed new roles. In 1990-91, during the first Gulf War, Mercy and Comfort deployed to the Persian Gulf. Except for Comfort's deployment to New York City following the September 11th terrorist attacks and during the initial stages of "Operation Iraqi Freedom," both ships have increasingly supported humanitarian relief operations. In 1994 Comfort served as a migrant processing center for Haitian migrants. Later that same year, she was again deployed to the coast of Haiti to provide combat surgical support for U.S. contingency operations in Haiti as part of "Operation Uphold Democracy." The hospital ship also provided care to injured Haitian citizens, and participated in the Civil Affairs Program to aid the rebuilding effort of the local healthcare system.

In 2002, Comfort deployed to the Baltic region in support of the NATO joint training exercise Medical Central Europe 2002 (MEDCEUR 02). During that mission, the hospital ship visited Lithuania, Latvia, and Estonia, mainly to exercise with NATO personnel but also to provide healthcare to citizens of those Baltic nations.

Following Katrina and Rita in 2005, Comfort steamed to the Gulf Coast to provide medical assistance to the victims of those devastating hurricanes. This time her complement included more than 900 personnel including civilian mariners, active duty personnel, and Project HOPE medical volunteers.

Although not deployed as frequently as her sister ship, USNS Mercy's history of providing humanitarian assistance dates back to 1987 when she deployed to the Philippines on a combined training-humanitarian mission. Following the 2004 Asian tsunami, Mercy deployed to the stricken region to provide medical care to the victims. In 2006, the hospital ship again deployed with military medical personnel and volunteers from several non-governmental organizations (NGOs). The ship spent 72 days delivering health care in medically underserved regions of the Philippines, Bangladesh, Indonesia, and East Timor.

The trend is unmistakable. More frequently, these two capable platforms, designed to support a Cold War medical mission, are showing their versatility and adaptability.

Navy Medicine recently visited Comfort at its berth in Baltimore while a training exercise—COMFEX—was underway and interviewed CAPT Albert Shimkus, NC, commanding officer of the hospital ship's medical treatment facility. Shimkus talked both about his highly unusual career that began over 40 years ago, and of Comfort's current and future roles. What follows are highlights of that interview.

When did you decide to join the service?

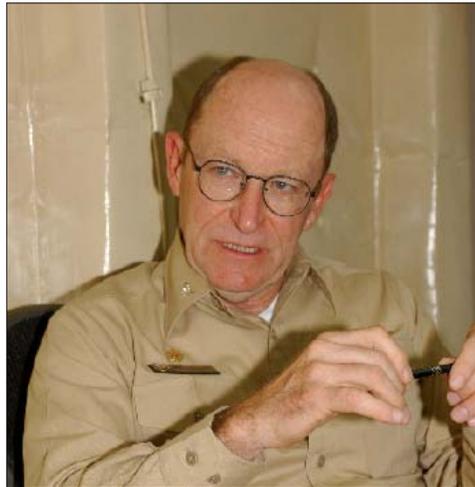
I didn't decide to join the service but Vietnam and the draft came along. I anticipated a draft notice and wanted to avoid being in the Army so I joined the Air Force. I knew I didn't want to be in the Army and knew the Air Force, at that point, had a better quality of life. So I enlisted in August of 1965. For some reason I was chosen to be a medic. My

first assignment was to the 551st USAF Hospital. I then was ordered to Vietnam and spent a year at Bien Hoa Air Base, and was there for the Tet Offensive in January of 1968.

I remember it vividly. The Viet Cong came in and overran the base. As medical providers, we were very busy doing our work. I survived that, and came back from Vietnam in November of '68.

When did you decide on nursing?

When I got out of the Air Force, I decided never again to put on a uniform because I didn't care for that kind of life. Instead I went back to college. I decided that maybe nursing would be interesting. Some very good Air Force nurses had been part of my career in Vietnam and at Otis Air Force Base. A friend of mine, Jerry Christy—a medic in Vietnam—decided to go with me to nursing school. We applied to Memorial Hospital School of Nursing in Worcester and started our nursing careers in 1970 at Memorial Hospital as the first two men ever admitted to this hospital-based school of nursing.



What was it like being a pioneer?

When I was in nursing school in Worcester the only thing I wouldn't do is wear a hat. At that time, nurses wore hats. I told the director at the school that I wouldn't be wearing a hat and they would have to come up with something else for me to wear. I ended up wearing a patch on my sleeve indicating my year of school. But Jerry and I never felt any kind of gender discrimination whatsoever. In fact, never in my Navy career have I ever felt anything negative with regard to my gender.

I passed my boards in Massachusetts and went on to Salem State College to obtain a BSN degree. Right after that, I was asked to join the faculty of the Salem Hospital School of Nursing, where I taught for 3 years. It was a wonderful job and I'd still be there today except that the Salem Hospital School of Nursing closed based on the pressure in the nursing profession to earn a baccalaureate degree as an entry level qualification.

That's what led me to the military again. I remembered my time in the Air Force as a very positive time. I first went to the Air Force but was told "We'd like you to come back in the Air Force as a 2nd lieutenant and your first assignment will be Minot, North Dakota."

I said, "That's a very nice idea, but I don't think I want to go to Minot, North Dakota." So I went over to my friendly Navy recruiter and she said that, based on my experience, they would make me an O-2—lieutenant j.g.—and allow me to go to the Naval Hospital at Annapolis. So that was my first duty assignment.

I went to Newport for OIS [Officer Indoctrination School], and then to Annapolis for 3 years, where I worked in ICU and the Medical/Surgical ward. I was then selected for the CRNA [Certified Registered Nurse Anesthetist] program. The Navy Nurse Corps sent me to George Washington University for a year, then a year at Portsmouth for a clinical internship. My first duty station as a CRNA was Naval Hospital Pensacola, FL. The first

duty station was often one in which you did difficult cases by yourself in preparation to be seen as a person who could practice independently in an operational environment at sea or with the Marines.

Female nurses weren't assigned to ships at that time.

Correct. At that time, until about the early '70s or mid-'70s, dental officers were administering anesthesia aboard aircraft carriers. Dental officers had a shore program for training in anesthesia as part of their dental residency. At some

point, it was decided that the Navy should have nurse anesthetists or physician-anesthesiologists at sea to handle anesthesia rather than the dentists. That's when the first CRNAs started going to sea. I was one of the first.

What was your first assignment?

On board the USS *America* [CV-66] as a TAD anesthetist. I joined the ship in the Indian Ocean with a general surgeon, CDR James Fitzgar. We were there for 6 months and did a lot of interesting cases. I could certainly see the need for assigning a CRNA there in support of the ship's company and the surgeon.

And that wasn't your last ship, either.

It was my first ship. If you counted up the number, I've probably been on 20 platforms on which I've done anesthesia, either as ship's company or TAD.

Where did you go from the *America*?

I went back to Pensacola. Because I enjoyed the professional challenge on *America*, I decided to compete for a PCS CRNA billet role on a ship. In 1986 I was selected to go to USS *Nimitz* [CVN-68], which had a requirement for a CRNA. I also practiced as a nurse intensivist in the ICU, ran the ward, and oversaw the medical training and medical response teams.

What was your next assignment?

I transferred to USS *Theodore Roosevelt* [CVN-71]. They were just building the ship at that time and I was the first anesthetist assigned to a PCU (pre-commissioning unit). It was an opportunity to build the ship from the keel up, assist in the development of the medical department, and help to train the ship's company as they came aboard.

What were your specific responsibilities?

Everything that had to do with the medical department was in our area of responsibility from training to educating the crew and ship's company on medical procedures, setting up the 3-bed ICU, the 40-bed ward, the 6 battle

dressing stations, obtaining the equipment and medications, setting up the operating room, and responding to medical emergencies inside the nuclear power plant—a huge responsibility on this 5,000-man ship.

So you were working in the shipyard in a hard hat.

Absolutely. The shipyard is a challenging and dangerous environment in which sailors must work, but it was something we had to do to allow the ship operate safely and effectively when it got underway.

Did you stay aboard after the ship was commissioned?

Yes, for a year. But before that, I was part of Fleet Surgical Team Two as its CRNA. We got underway on USS *Saipan* [LHA-2] and USS *Shreveport* [LPD-12] for contingency operations within some areas of the world in crisis at that time. Sea mines were being dropped in the Red Sea and the ship responded to that situation.

My next assignment was on the PCU for the USS *George Washington* [CVN-73]. It wasn't as intimidating as the first time around because I was more familiar with the environment. Therefore, I was more efficient and effective in getting things done.

At some point, you had an affiliation with the *New Jersey*.

Yes. I was the anesthetist during the last WESTPAC deployment of the USS *New Jersey* [BB-62]. It was in the late '80s. Wooden decks, big ship, big guns. Being in a World War II battleship environment was remarkable. As a matter of fact, during this deployment, the *New Jersey* was the first battleship after the *Iowa* accident to fire its 16-inch guns.¹ The commanding officer had the entire wardroom come in and listen to the pre-fire briefs. It was the CO's philosophy of having everyone in the wardroom understand all elements of the process.

During your career you were assigned to Naval Hospital Guam.

Yes. I was assigned as Director of Nursing following graduation from the Naval War College. This was the first time in recent memory that a nurse anesthetist had become Director of Nursing. I had a great staff and they allowed me to be successful. It was one of the best assignments I've ever had in that the nursing component was involved in every element of the hospital. I was engaged in everything from emergency medicine, to ICU, to medical surgical nursing, to the executive steering council.

Where did you go after Guam?

I was asked to be professor of National Security Decision Making, Policy Making and Implementation at the Naval War College.

¹During a training exercise in April 1989, the center gun on USS *Iowa's* (BB-61) turret two exploded, killing 47 men.

Do you know why you were asked to do that job?

I was a student at the War College a few years before and the senior faculty have a selection process for recognizing potential military professors. If you are interested in being an instructor, they identify you and you are interviewed and so forth. I was selected as a potential candidate to be an instructor at the War College but Navy medicine and the Navy Nurse Corps wanted me to go to Guam so I went there first. Then the offer was made again through Navy medicine for me return to the Naval War College as a faculty member after our Guam tour. So I taught policy making and implementation in the National Security Decision Making arena for 2 years. In fact, I've been volunteering as a professor in national decision making. I've taught in the continuing education department for the last 9 years. It's called the College of Distance Education. I've taught in Naples, Guam, Guantanamo, and now at the Washington Navy Yard.

The War College education and being a faculty member allows the individual a perspective of understanding the big picture and then aligning your organization and your people to understand why we exist as the Navy Medical Department in support of a greater effort in the Navy and the nation.

While I was at the War College, I created an elective called "Unconventional Warfare and Uncertain Times." And remember this was in 1995 when biochemical warfare was just beginning to become important as far as a strategic component of the War College. I developed this elective because I thought the line officer needed to have some understanding of chemical and biological warfare. The offer was oversubscribed every time I gave it because the war fighter felt that this was something they needed to have so they could align their assets to this new threat that was on the horizon.

I was selected for captain while at the War College and was subsequently selected as executive officer for Naval Hospital Naples. During my tour in Naples, I worked for two great COs, CAPTs Spier and Adams. They allowed me to actively observe what good leadership was in Navy medicine and the Navy. The COs allowed me to have a great influence on the way the command was run. And that experience as their XO allowed me to be a more successful CO.

Where did you go from there?

I was selected to become the commanding officer of the Naval Hospital at Naval Base Guantanamo Bay, Cuba I think I went down there to close the place down. Guantanamo had lost its strategic importance as the Cold War was over and Fleet Training Group moved to Jacksonville. Guantanamo was just a sleepy little place that had about 5,000 residents. The hospital was there to take of the base population to include the Cuban exiles.

It was a wonderful opportunity, and my time there was critically impacted by the events of 9/11. GTMO then became the focus of world attention when the Joint Task Force Guantanamo was set up as Joint Task Force 160. I became the Joint Task Force Surgeon for the detainee mission.

Then you were the first nurse to be a task force surgeon.

Yes, I believe so. I was the first nurse anesthetist to be a commanding officer and an XO, and the first nurse to be a joint task force surgeon. The surgeon title is simply a title, not a skill. I don't do surgery. But it was a title that allowed me to have the opportunity to exercise oversight over all aspects of medicine for both the detainees and the Joint Task Force. I had responsibility for the Marine Corps medical components, initially, and then when the Army and National Guard fell into the mission, I kept the title and continued to have that responsibility to take care of the soldiers and the detainees.

In a talk you gave several years ago, I recall you saying that taking care of migrant patients was easy because they were a friendly population that appreciated the healthcare. With the detainees, you had a group that were not only unfriendly but hostile.

Yes. The detainees were initially hostile to the guards and the medical staff. And that was a component of healthcare delivery that I had not been involved with before. But, that being said, it didn't affect the quality of care the detainees experienced. Many detainees came in injured and sick and they got the best possible care we could deliver. The standard of care we gave the detainees was at the level of care we would give an American service member. We gave them first-rate care despite their hostility toward the United States.

You had to come up with a special regime for treating these people, considering that now even your healthcare providers were at risk.

That's right. We were very conscious of the fact that they wanted to hurt Americans. Therefore, the patients were not seen in isolation in a private area. We always had a guard with the provider as they were examining the patient. We were also certain there were safeguards in place when the detainees were being seen. That being said, I can't recall any aggressive behavior of a detainee toward a healthcare provider. They appeared to welcome the care they received.

As I recall, that mission was set up fairly quickly.

Overnight. Within 2 weeks we developed Camp X-Ray and the medical component, which was quite rudimentary but acceptable. Then we built a Navy hospital for the detainees in 4 months. So we had a brand-new hospital there for them when we moved them to Camp Delta. We built an ICU in the Naval Hospital in Guantanamo for

really sick detainees who needed intensive care post-surgically or medically. That's been used 20 or 30 times as an ICU. Prior to that, anyone who was very sick or seriously injured was air evacuated to the United States.

What kinds of diseases did you see in the detainee population?

Leishmaniasis, malaria, and systemic diseases they had had all their lives. We had fresh injuries from the battlefield. We did amputations, enucleations—many significant medical and surgical challenges. And all the detainees did very well medically and surgically.

Was it also your responsibility to see to their mental welfare?

We developed and built a mental health ward—Delta Block—which took care of the most seriously mentally ill of the detainees. We had a physician and a mental health staff engaged full-time in the care of the mentally ill.

Where did you go after that assignment?

The Surgeon General invited me to BUMED and I became Navy medicine's lead on the Medical Cross-Service Group in the 2005 BRAC arena. It was another remarkably interesting job in that we were transforming military medicine in the joint arena into something that will occur in the future. It involved coordinating and consolidating assets to become a different type of military medical department based on synergies of each service so we become better and more efficient. And I think we succeeded.

Was that a difficult transformation for you to make from the healthcare arena to this futuristic planning or did your War College experience help you?

It helped, plus we had superb Army and Air Force O-6s who were very well seasoned in their professional backgrounds. And, Navy medicine assigned CDR Nancy Hight, MSC, to our team. She made a huge difference and very positive difference to the analytical process. We knew we weren't going to be liked necessarily and we needed to set the agenda to become something we were not at that time, which was to become more alike than unlike. Strategically, it was a very positive experience. Our Surgeons General agreed to agree that this was the way it was going to be. So there were difficult decisions to be made but they were based on the country's need for efficiency and effectiveness in the delivery of healthcare to our beneficiary population.

Then you were selected to head this medical treatment facility?

Not quite. There was an interim. I was selected as the Deputy Commandant Naval District Washington by the Commandant Naval District Washington at the time, RDML Jan Guadio. He arranged with our Surgeon General for me to leave BUMED and work for him. BRAC

was over and I became the Deputy Commandant of Naval District Washington, the first time a staff corps officer had become a deputy commander of any of the Navy Regions.

What were your responsibilities in that new position?

I was responsible for 51,000 military and civilian personnel and \$18 billion dollars of plant coordination for 18 installations. So I was XO for the admiral at Naval District Washington headquartered at the Washington Navy Yard and was 50 yards from my home. I still live there.

That was an 18-month tour and then came the opportunity to become commanding officer of the medical treatment facility on USNS *Comfort*. This has been one of the most remarkable jobs in my Navy career in that it combines everything I love about the Navy: medicine, being on a ship, being operational, taking care of our fellow human beings. It's been the capstone of my career.

So this was a natural transition for you.

Yes. The criteria for selection for command on *Comfort* was post-MTF command. So both CAPT Joe Moore and I, who is my counterpart on *Mercy*, had medical treatment facility fixed tours as commanding officers. As commanding officers of medical treatment facilities we know what supposed to happen in a hospital. So whether it's on a ship or fixed, the hospital piece still stays in place. CAPT Moore and I are very careful in articulating that we're not driving the ship. We're responsible for the MTF on the ship.

The MTF on *Comfort* is a hospital housed in a ship's hull.

Yes. We have three primary missions. One is taking care of our service members who are injured in war. We have a disaster relief mission, which means responding to a national disaster within our domestic borders, or overseas like *Mercy* did in the tsunami relief and as we did following Hurricane Katrina. And we also have the humanitarian assistance mission that *Mercy* has been participating in during its recent deployment to Indonesia, the Philippines, and Bangladesh.

Both vessels were designed for the Cold War but obviously they've morphed into something else.

With *Mercy* and *Comfort*, these platforms are able to be used in areas of the world we never thought they'd ever be functioning in. Both ships have proven to be remarkably versatile far beyond expectations. So these platforms used as a soft power projection of the United States in areas of the world that require this kind of assistance will make a huge difference in our childrens' and grandchildrens' lives in that we will have affected people at a point in their lives where health care is important. And they will think favorably of our nation in our ability to provide health care in their communities.

You were recently out with *Mercy* in Indonesia. What was your purpose in going there?

My view and CAPT Moore's view is that we need to have the two hospital ships function very similarly. So I deployed with *Mercy* to participate in that mission to understand the complexities in developing a successful mission with humanitarian assistance as a primary goal. This mission the *Mercy* did—and CAPT



Moore let me be part of it—integrated NGOs such as Project Hope, Operation Smile, Aloha Medical Mission, and Army and Navy healthcare professionals in order to provide a seamless provision of healthcare both on the ship and ashore. Being able to be part of that allowed me bring that experience back to *Comfort* so if we get underway for a similar mission next year we will be able to do it successfully.

What mission do you anticipate for the ship next year?

There's nothing specific but if we're called upon by National Command Authority to do any mission, we're ready.

Today, *Comfort* is undergoing an exercise called COM-FEX. How often do you hold these exercises?

Quarterly. We bring people who haven't been on board a ship before to familiarize them with the ship's environment for the first 2 days. Then the last 2 days is an orientation into the departments in which they will be working so they will be ready to come aboard, get underway, and provide the care almost immediately.

So, the role of these ships in solely supporting the war fighter has really changed.

It's evolving and becoming more flexible than anyone ever imagined. CAPT Moore and his crew and CAPT Ellingham and his crew on *Comfort* have proven that point dramatically.

I recall talking with you just after you were selected to command *Comfort* and you were quite thrilled. I'll bet you still are.

I'm privileged to be the commanding officer of the MTF on this ship! ⚓



First Blood on Valentine's Ridge

Raymond Felle was born in California and raised in Oregon. He joined the Navy in 1966 with the troop buildup in Vietnam. Although he sought shipboard duty, it was during hospital corps school that he realized the Navy had other plans. Felle was assigned to Field Medical Service School at Camp Pendleton. As he now points out, during his entire stint in the Navy, he was never on a ship.

In October 1967, the 20-year-old corpsman received orders to Vietnam. Upon arrival, he was assigned to the 3rd Battalion, 9th Marines, and met up with his new outfit at Camp Carroll near Dong Ha. He would soon experience combat for the first time.

I remember the smell, the heat. I remember looking at the mountains around us and thinking, “Am I gonna make it here? Did I make the right decision?” My dad died while I was in boot camp and I was the only surviving son. So my mom didn’t want me to go to Vietnam. She told me that being the only surviving son, I didn’t have to go. But I told her it was my duty to go. Did I really make a wise decision coming to this country and being with the Marines? I was proud to be with them but I didn’t know a hell of a lot about them. I didn’t know how to survive. I was a Navy corpsman—not a Marine. At least not yet.

They gave me all my gear and my Unit 1 and, from that point forward, they started looking at me as the person who would treat and take care of them. I was also issued a .45. Before I went into the service, I was familiar with shooting guns. I had spent many hours hunting so I knew how to shoot rifles and pistols. I just wasn’t familiar with the automatic. The pistol they gave me was pretty beat up. It was probably from World War II. The barrel was loose and I couldn’t hit something 15 feet away. It made a lot of noise but it just wasn’t very accurate. It probably came from the previous corpsman—and the one before him and the one before him.

When I was in battle, I usually had an M16 to take with me. I’d get a rifle from the people I was treating. They’d either be wounded or killed and I’d just take their rifle. Since I wasn’t responsible for it, I could lay it down to use both hands. If I lost it, I could always get another one.

We got on a truck convoy on the 24th of December [1967] and headed out Route 9, which pretty much fol-

lowed the McNamara Line¹ of combat bases. We finally ended up at the Rockpile, which was very impressive. It was a huge pile of rocks with clouds and fog layers hovering over the top. It was just mystical. You knew the enemy was out there somewhere. I had an eerie feeling and certainly didn’t feel secure. I pulled into the BAS [battalion aid station] there and checked in with Jerry Behrens, my battalion surgeon. He took my name and asked me what I needed. I asked him where I was going but he wasn’t sure. We had Christmas dinner at the Rockpile.

On 14 February we went out on a 2-day patrol. We left early in the morning and moved up about 2 miles west of Ca Lu toward Khe Sanh. Very early that morning, CAPT Alexander Ward, our commanding officer, cut his finger. It was probably about 2 o’clock in the afternoon when I saw him talking with someone. We had passed him by as we lined up our platoons to go up on what would later be called “Valentine’s Ridge.” I told him he needed to take care of the cut. He said, “I don’t need to.”

I said, “You’ve got to put a Band-Aid on it or you’re going to get jungle rot and it will get infected. So he let me put a Band-Aid on his finger and that was the last time I ever saw CAPT Ward.

Someone then said they had seen some NVA moving out of a valley up onto Valentine’s Ridge. It was about 3 o’clock in the afternoon. We were heading down into a valley and across a creek. We then started up the side of Valentine’s Ridge on what was a well-made trail. Because

¹In 1967, Secretary of Defense Robert McNamara ordered the construction of an electronic infiltration barrier below the DMZ. It consisted of seismic and electronic sensors designed to track vehicular and human movement along the Ho Chi Minh Trail.

the mountain was so steep, the trail zigzagged its way up the side of the mountain. We had gotten part way up the trail when our platoon commander, LT [Michael] Holladay, made the decision to get off the trail, cross a little gully, and head up the side.

About 15 of us then got off the trail. We were trying to hustle up the side of the hill, but it was so steep that rocks were rolling back down again. We had gotten pretty close to the top of the ridge when an NVA fired an RPG which hit a rock, blowing it apart and throwing shrapnel and rock fragments in all directions. It was a trap! With three platoons heading up the side of the hill, they opened up on the second platoon with .50 caliber machine guns. I and four other men to my side and front were wounded. One of the Marines in front of me had half his rear end blown off.

We returned fire. For me, it was my first contact and I was pretty scared. Someone began yelling "Corpsman up!" I wasn't very far from him.

There was tremendous confusion—mortar rounds, RPGs, and machine gun fire. My part was taking care of the wounded. Even though I had been wounded, I didn't even know it because I was so scared and the adrenalin was running.

One of the guys had his M16 jam just when he had one of the NVA in sight. I also remember that someone threw a grenade toward the RPG nest, but it hit a tree and started rolling back towards us. Someone said, "Get down! It's rolling back toward us!" We hid behind a log so we were pretty well protected from the blast.

I then attempted to control the bleeding on a gunny sergeant. Because he was starting to feel pain, I gave him a shot of morphine. I remember losing contact with the command group until we were just our own little group of people and didn't know where everybody else was.

Then they started lobbing in mortars. We lost contact with the command group—CAPT Ward, our commanding officer, and LT [William R.] Reese, our executive officer. Early in the battle, a mortar had landed, critically wounding both of them. They died a short time after that. The battalion corpsman, HM2 [Larry J.] Goss, was also killed by that mortar round.

So the battle raged on and we took out the RPG nest. We couldn't contact the rest of the company so Lt. Holladay took what was left of our platoon and the wounded, and we went over the top of the hill and waited for instructions from Ca Lu. Just before we did that, he called in jets which dropped napalm and 500-pounders on the enemy. They dropped those bombs so close to us that we were told to set off green smoke so they would know where we were. Those explosions literally lifted us off the ground when they hit. I could only imagine what they did to the NVA. I just remember the big shards from the bombs cutting off the tops of trees in that triple-canopy jungle, and pieces of those trees falling down all over the place.



HM3 Raymond Felle holds a Chinese grenade.

We got off the hill that evening and waited on Route 9 for more reinforcements, which came up at 2 o'clock the next morning. Then we took our wounded and went back to Ca Lu. The rest of 3rd Platoon was still up on that hill and India Company 3/9 went up to assist them and bring them down. The final tally included 10 Marines and 1 corpsman killed.

I was so scared I didn't even know I was injured. I had a perforated left eardrum, shrapnel in my neck, back, and the side of my arm where it wasn't protected by my flak jacket. And I had blood all over me from treating people.

I gave them morphine, and was able to control the bleeding with large battle dressings and give moral support. That's all I could do in the field. I had serum albumin but it was kind of useless. It's hard to start an IV when you can't see the person's arm in the dark. Many times the people you were dealing with were dehydrated anyway. Serum albumin is a volume expander and when you inject it, it sucks fluid out of the surrounding tissue to expand the fluid volume. If the person is bleeding severely, he is already dehydrated so you're not going to do him a lot of good. In the field, I could do better by just controlling the bleeding rather than trying to start a useless IV.

At 2 o'clock in the morning they told us to start heading back down to Route 9. That was 1st Platoon and 2nd Platoon. We were meeting up with stragglers coming in out of the jungle. It was dark and they couldn't see. We just coaxed them in by radio, telling them which way to go.

This was the first battle many of us had been in so we were pretty shook up. I was scared but did my job. I did what I had to do and earned the respect of my platoon. I was no longer "Squid." I was "Doc." ⚡

Raymond Felle resides in Portland, Oregon.

In Memoriam

CAPT Joseph Page Pollard, MC, USN (Ret.), flight surgeon and division director at the Office of Naval Research, died 15 October 2006 in Arlington, VA.

Dr. Pollard was born in Minor (Essex County), VA, on 15 September 1913. After receiving his Bachelor of Science degree from the College of William and Mary, Williamsburg, VA, in 1935, he attended the University of Virginia at Charlottesville where he received his M.D. degree in 1939. He served in the Medical Corps of the U.S. Navy for 27 years, retiring in 1968.

Dr. Pollard attended many special courses in military medicine, but was especially concerned with aviation medicine, being a designated naval flight surgeon and having served aboard the aircraft carriers USS *Hornet* (CV-8), USS *Yorktown* (CV-5), and USS *Coral Sea* (CVB-43), and with numerous aircraft squadrons. He witnessed the Battle of Midway from his battle station on *Yorktown*, and when the order to abandon ship was received, he remained aboard until all casualties were accounted for. He and the commanding officer were the last to leave the mortally stricken carrier.

Dr. Pollard went on to establish and implement the plan for the air transportation of patients used by the Navy in World War II and was commended for this effort by the Secretary of the Navy.

In the post-World War II years, Dr. Pollard concentrated on medical research and development and held numerous research assignments, both operational and staff, including his service on the staff of the Research and Development Board in the Office of the Secretary of Defense; in the Office of Naval Research; as Director, Research Division and, also, as Assistant Chief for Research and the Military Medical Specialties of the Bureau of Medicine and Surgery.

During his naval career, Dr. Pollard made significant contributions to the high-altitude balloon flight series known as STRATOLAB, which set a world altitude record of nearly 114,000 feet using life support systems and medical monitoring provided by the Navy; the selection of the three Navy and one Marine Corps Mercury astronauts of the original seven and their training in meeting the stresses of space flight; the space flight experiments, in cooperation with the Army, of squirrel monkeys "Old Reliable," "Able," and "Baker;" the national effort in bioastronautics as it progressed in the 1960s by providing Navy scientists' technology and facilities to the National Aeronautics and Space Administration; and serving as the Navy's member on

various committees of the National Academy of Sciences/National Research Council. For several years he was the Director, Astronautical Medicine Division for the Bureau of Medicine and Surgery.

After retiring from the Navy, Dr. Pollard became Director, Biological and Medical Sciences Division of the Office of Naval Research where he was responsible for the scientific and technical management of the Navy's contract research programs under the general areas of Physiology, Biochemistry, Microbiology, and Medical and Dental Sciences, both domestic and foreign.

His professional affiliations included: member of the Phi Beta Kappa Society, Diplomate and Oral Examiner of the American Board of Preventive Medicine, Fellow of the American College of Preventive Medicine, and Fellow of the Aerospace Medical Association. He was a member of the International Academy of Aviation and Space Medicine, the Association of Military Surgeons of the United States; the Academy of Medicine of Washington, DC, and the Cosmos Club. He was also a charter member of the Undersea Medical Society. He was included in the American Men of Science and was an active participant in the affairs of the Aerospace Medical Association and the Aerospace Medicine Panel of the Advisory Group on Aerospace Research and Development (AGARD/NATO).

Dr. Pollard was the recipient of the Theodore C. Lyster Award of the Aerospace Medical Association for outstanding accomplishment in the field of aerospace medicine.

He lived in the Washington metropolitan area since 1949 and kept close ties to his family roots in Tappahannock, VA. He was married to Mary Ruth Pollard from 1941 until her death in 1970; and Marietta Klee Pollard from 1971 until her death in 2005. Dr. Pollard is survived by three children, Ann Pollard Cleveland, Joseph Lawrence Pollard, Mary Kathryn Pollard Strong, six grandchildren, and four great-grandchildren.

Dr. Pollard appeared in the Bureau of Medicine and Surgery's 2006 release of *Battle Station Sick Bay*, part four in the six-part series "Navy Medicine at War." 



RADM Russell L. Marlor, MC, USN (Ret.) died on 4 August at his home in Springfield, VA. He was 76. Dr. Marlor was born in Tooele, UT. Awarded an NROTC scholarship at the University of Utah, he graduated in 1952 and was commissioned an ensign. His first assignment was aboard USS *O'Brien* (DD-725). This was followed by training at the U.S. Naval Submarine School and a tour aboard USS *Redfish* (SS-395), where he qualified in submarines.

Released from active duty with a reserve commission in 1995, he attended graduate school at the University of Utah, where he earned an MS in medical entomology. Later, he entered the University of Utah College of Medicine.

Dr. Marlor returned to active duty in 1962. He served a rotating internship at Naval Hospital San Diego, followed by a year of training as a nuclear submarine medical officer. He was assigned to the commissioning crew of USS *Stonewall Jackson* (SSBN-634) followed by assignment as precommissioning and Blue Crew medical officer of USS *Kamehameha* (SSBN-642). He then served on the staff of COMSUBRON One.

In 1968, Dr. Marlor began residency training in preventive medicine at the School of Public Health, University of California, Berkeley, and was

awarded a master of public health degree the following year. After completing training in 1971, he served as epidemiologist at the Navy Environmental and Preventive medicine Unit 5 (NAVENPVNT-MEDU-5), San Diego. In 1974 he became officer-in-charge of NAVENPVNTMEDU-7 in Naples. He was then assigned to BUMED in 1978, first as head of the Preventive Medicine Branch, then as Director, Occupational and Preventive Medicine Division, and finally as Director of the Undersea and Radiation Medicine Division.

Dr. Marlor assumed command of Naval Hospital Groton, CT, in 1983. He was promoted to flag rank in 1986 and then assigned to the staff of the Commander in Chief, U.S. Pacific fleet as Fleet Surgeon with additional duty as the Surgeon U.S. Pacific Command. In 1990, he became Director, Medical Plans and Policy Division, Chief of Naval Operations. He retired in 1991.

RADM Marlor was a diplomate of the American board of Preventive Medicine, member of the American Public Health Association, the Undersea Medical society, and the Association of Military Surgeons of the U.S. He held the Legion of Merit, the Meritorious Service Medal, Korea Service Medal, the United Nations Service medal with two stars, the China Service Medal, and the Philippine Presidential Unit Citation. 

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