

# *Navy Medicine*

September-October 2008



*1986-2007*

# NAVY MEDICINE

*Official Publication of the U.S. Navy Medical Department  
Volume 99, No. 5  
September-October 2008*

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

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

Personal subscription address changes: write to Navy Medicine, Bureau of Medicine and Surgery, M09B7C, 2300 E Street, NW, Washington DC 20372-5300, or email Janice. Hores@med.navy.mil or 19native47@verizon.net. Include old and new addresses when submitting a change of address to the above.

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

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**Cover:** In March 2007, HN Lucas Emch died in Iraq when his vehicle was hit by an improvised explosive device (IED). A portrait of this young man's life appears on page 23. Official Navy Photo.

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

# C O N T E N T S

## FEATURES

- 23 **A Corpsman's Story**  
*HMCS(FMF) M. D. Lubold, USN*
- 25 **From Every Direction**  
*R. Hudson*

## DEPARTMENTS

- 4 **ADMIRAL'S CALL**
- 4 **LETTERS TO THE EDITOR**
- 5 **DEPARTMENT ROUNDS**
- 27 **FORUM**  
**Building A Sea-Based Medical Support System PART V: The Case for Joint Medical Command and Control**  
*CAPT A.M. Smith, MC, USNR, (Ret.)*
- 31 **A LOOK BACK**  
**Navy Medicine 1948**

### Articles and Book Review Submissions

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

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

- Book reviews should be 600 words or less.
- Introductory paragraph must contain: Book name by author. Publisher, city, state. Year published. Number of pages.
- Reviewer ID: sample:  
CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.

### **SAVE A TREE**

*If you would like to receive your issue electronically via email in PDF format, please contact Janice Marie Hores, Managing Editor, at [Janice.Hores@med.navy.mil](mailto:Janice.Hores@med.navy.mil) or [19native47@verizon.net](mailto:19native47@verizon.net)*

## TIER 1 STRATEGIC GOAL: DEPLOYMENT READINESS

In June 2008, I rolled out the new Strategic Plan, including eight Strategic Goals which serve as a framework for all functions of Navy medicine.

The strategic goals will keep us focused on fulfilling the vision for an agile, flexible, ready, and professional medical organization committed to our mission force health protection and to our patient and family focused concept of care. These goals also ensure we are aligned with the 21st Century Maritime Strategy and directly support our role in the Navy and as part of the joint medical component with the other services. These goals do not describe every work function we perform, but is the framework that all our functions should support.

This recurring column is dedicated to communicating the strategic goals and to demonstrate how today's optimization of the goals moves Navy medicine forward.

The first strategic Tier 1 goal discussed in this venue is "Deployment Readiness." Deployment readiness means that every member of Navy medicine will be fully deployable based on successful achievement of all training, administrative, and medical readiness requirements. Three Tier 2 goals support Deployment Readiness.

First, execute expeditionary training plan. A tangible, operational example of this goal is the creation of the Medical Education Training Center (METC) in Ft. Sam Houston, TX. I was pleased to serve as the commissioning ceremony guest speaker, and noted, "We are committed to one integrated inter-service education and training system that leverages the assets of all DOD healthcare practitioners. It is the right thing to do."

CAPT Greg Craigmiles, commanding officer of the Naval Medical Training Center, the Navy medicine component of

METC, pointed out that U.S. military personnel in Iraq and Afghanistan are experiencing the lowest battle mortality and disease non-battle injury rates in history, due in large part to exceptional military medical personnel and their training.

"The training we deliver to our corpsmen and medics will save lives on the battlefield," he said. "Therefore, we must continue to provide the best possible support to our sailors, soldiers, and airmen in all aspects of their training and development."

Second, complete periodic administrative deployment reviews. This second Tier 2 goal is critical to the viability of the deployment readiness of our force.

In addition to deployment training and administrative reviews, we must complete individual medical readiness (IMR) assessments for all Navy medicine forces using the Medical Readiness Reporting System, which is the third Tier 2 goal under Deployment Readiness.

"It is imperative that our physicians, nurses, technicians, and support staff are medically ready to provide world-class health services to our soldiers, sailors, and Marines and their families

Our ability to implement the Deployment Readiness strategic goal will be evaluated by measuring all Navy medicine personnel training status (BSO 18 T-Status), administrative status (BSO 18 A-Status), and individual medical readiness (BSO 18 IMR) status.

In the near future, command level action plans will be developed to implement the Tier 2 goals. These local level plans will describe action tasks and activities to meet the established metric targets.

Our next strategic goal to be featured in this column is "Agile Forces." 



### LETTERS TO THE EDITOR

Today I reconnected with a retired Navy optician whom I served with in Vietnam in 1968. We reminisced about that year which we served together: I was a LTJG and he was a more seasoned sailor.

After I hung up I surfed the web a bit looking for information on the Naval Support Activity Hospital DaNang from that time period hoping to find the names of some of my old shipmates.

I ran across the *Navy Medicine* issue from earlier this year and found two articles that brought back good memories from my time in Nam. The article, "The Spec on Specs," tells a story similar to our optometry clinic in DaNang, and the article by CAPT Harry Dinsmore "Anguishing Decisions" is a good look back at NSA Hospital DaNang. I was the third Navy optometrist to serve in a combat zone being preceded in country by then LCDR Jim Johnston and LCDR L.M. "Bud" Roach.

Our home was a Quonset hut with two eye lanes that operated 7 days a week. Prior to the establishment of that clinic, patients were medevacd out of country for eye exams and glasses! Attached to the back of our clinic was a modified southeast Asian hooch that was an optical shop turning out eyeglasses in 15 minutes similar to the service CDR Kato provides in Kuwait. At that time our only lenses were single vision glass that were heat treated to provide additional impact resistance. In my 21 years of active duty, I had many terrific assignments but the most gratifying in terms of helping fellow sailors, Marines, soldiers, and airmen was the year I spent in South Vietnam.

Sincerely,

CDR James F Socks, MSC, USN (Ret.)

## DOD BREAKS GROUND ON MASSIVE MEDICAL EDUCATION TRAINING CAMPUS

**A**n historic groundbreaking ceremony was held on 10 July in San Antonio, TX. This groundbreaking marked the official beginning of the facilities construction phase of the Medical Education Training Center (METC).

METC is the largest consolidation of service training in DOD history and will be the world's largest military medical education and training institution.

Air Force, Army, and Navy medicine were represented by MGEN Melissa Rank, USAF, Assistant Surgeon General, Medical Force Development; MGEN Russell J. Czerw, USA, Commander, U.S. Army Medical Department Center and Commanding General of Ft. Sam Houston; and RDML Richard Vinci, Commander, Navy Medicine Support Command in Jacksonville, FL. Vinci is responsible for Navy medicine's manpower, education and training, and is a member of the METC Flag Officers Steering Committee.

"The METC stakeholders come from all the services, and I could see that reflected in the people attending this ceremony," Vinci said. "The Navy Surgeon General, RADM Adam Robinson, probably said it best – we are all committed to an integrated inter-service education and training system that leverages the assets of all DOD healthcare practitioners. It's the right thing to do."

MGEN Rank is chair of the METC Flag Officers Steering Committee and was the keynote speaker for the ceremony. "This historic event marks the beginning of another chapter in the quest for finding a common purpose in the training of military medical professionals in whose hands lay the lives of the nation's heroes – the men and women serving in the armed forces," Rank told the tri-service audience. "There can be no greater reason than that, for us to get this right."

The tri-service METC is scheduled to open in phases between 2010 and 2011 and will be the largest consolidation of service training in DOD history. The targeted completion date is prior to 15 September 2011, the 2005 Base Closure and Realignment Commission (BRAC) initiative deadline, said CDR Chris Garcia from the tri-service METC Transformation and Integration Office (TIO).

The 11 facilities under construction include three 1,200-student dormitories, a dining facility, five medical instruction facilities, a Navy and Air Force command building, and a field training site located off Ft. Sam Houston at Camp Bullis just outside San Antonio.

The planning process that led to the ground breaking has been extensive. Garcia said identifying the facility require-



Artist's rendering of future campus.

ments was a team effort between the METC TIO; the Army, Navy and Air Force medical learning centers located across the nation; and several other military organizations.

"We had to first come together and identify what the new METC would look like and how we would work together," Garcia said. "It's a process that is still very much underway. The Healthcare Inter-service Training Office (ITO) led the efforts to identify our education and training program curriculum commonalities so that joint curricula could be developed and facilities could be appropriately planned and designed. There are still many areas where each service will still teach their service-specific curricula, too."

The ground breaking ceremony was held on the future site of the third and fourth medical instruction facilities. These two buildings will house the facilities and equipment necessary to provide advanced training for corpsmen and medics in a variety of advanced enlisted medical specialties, including surgical, medical laboratory, urology, mental health, preventive medicine, histopathology, ENT (Ear, Nose and Throat), cytotechnology, and electroneurodiagnostic technology.

Another new building, in conjunction with an adjacent existing building, will house the three services' initial-entry medical training programs for personnel just entering the enlisted medical field – the Hospital Corpsman, the Air Force's Aerospace Medical Apprentice and the Army's Health Care Specialist. The contract for these two facilities is expected to be awarded in September.

"Contracts have already been awarded, and the contractor has started moving dirt on the first two medical instructional facilities, the first two dorms, the dining facility, and the Navy/Air Force command building," Garcia said. "The fifth medical instructional facility is in the final phases of facility planning with the contract most likely being awarded in March 2009. Everything is on target for a successful move in and stand-up of the campus by the BRAC mandated deadline." ✍️

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

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## SLEDGEHAMMER STARTS CONSTRUCTION OF NMCP'S NEW PATRIOTS' INN

With the swing of sledgehammers 3 July, construction began for a new permanent area for injured service members and wounded warriors at Naval Medical Center Portsmouth. The \$3.3 million Patriot's Inn project will include Fleet Liaison, disability counselors, Department of Veterans Affairs representatives, and other services to support service members in a central location as they transition from inpatient to outpatient care. "This represents a great sea change, a great culture change," said NMCP then Commander RDML Matthew Nathan. "The goal is to provide great care. We'll be with them, watching, helping until they are ready to go home."

The Patriots' Inn will include 13 private rooms with queen-size beds designed more like hotel rooms than hospital rooms. The project also will include sustainable furnishings and finishes such as bamboo flooring and products made with recycled content. The entire project will occupy approximately 18,500 square feet.

"I think this is a great idea," said CPL Aaron Foster, USMC, who was wounded in Iraq and was treated as an inpatient in the current Patriot's Inn on the 5th floor of Building 2. "I'm very happy this is now a reality."

"This sends the message that we're not going to drop your care at any point," said Nathan. "Their care is job one for us. They'll know that help is always just a few steps away."

Building 3 served as the primary hospital from 1959 to 1999. When the current Charette Center (Building 2) opened, much of Building 3 was renovated for administrative space and clinics. The Patriot's Inn is one of the last projects in the building's renovation, and is set to be completed in June 2009.✍

*—Naval Medical Center Portsmouth Public Affairs.*



Photo of sketch by MC1 Eric Deathridge, USN

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## DOD ESTABLISHES NEW PHYSICAL DISABILITY BOARD

The Defense Department announced the establishment of a new Physical Disability Board of Review (PDBR) to review disability ratings of wounded warriors and provide another avenue of administrative recourse for our wounded veterans. The Air Force has been designated as lead DOD component for operation and management of the PDBR.

"The PDBR has no greater obligation to our wounded, ill, and injured service members and former service members than to offer fair and equitable recommendations pertaining to the assignment of disability ratings," said Under Secretary for Personnel and Readiness David S.C. Chu.

The PDBR will reassess the accuracy and fairness of the combined disability ratings assigned to service members who were discharged as unfit for continued military service by the military departments with a combined disability rating of 20 percent or less, and were not found to be eligible for retirement. The PDBR will not review the military departments' determinations of fitness for continued military service. Instead, the PDBR will review the combined disability ratings assigned to the specific conditions that resulted in a member

being declared unfit for continued military service, acted upon by the military department Physical Evaluation Boards.

Any service member may have his or her case reviewed by the PDBR if he or she meets certain conditions. The member must have been separated from the Armed Forces between 11 September 2001 and 31 December 2009, due to unfitness for continued military service resulting from a physical disability under chapter 61 of title 10, U.S. Code. Additionally, the member must have received a combined disability rating of 20 percent or less, and have been found not eligible for retirement. By law, once adopted by the service secretary, a PDBR recommendation is final, and removes the service member's option to pursue subsequent review through the respective military department's Board for the Correction of Military Records.

Service members may request the PDBR review their case if these conditions are met. Alternatively, the PDBR may itself decide to review an individual's case, pending consent of the service member. Generally, individuals will apply for PDBR review through their respective military department; however more specific guidance will be provided by the Air Force.✍

*—Office of the Assistant Secretary of Defense News Release.*

## NEW WALTER REED NATIONAL MILITARY MEDICAL CENTER CONSTRUCTION UNDERWAY

The future of military medicine began a new era on 3 July as President George W. Bush helped break ground for construction of the new Walter Reed National Military Medical Center.

The new medical center comes as a result of the 2005 Base Realignment and Closure process to create an integrated state-of-the-art medical facility for military members.

Both the National Naval Medical Center and Walter Reed Army Medical Center will combine to treat and care for service members and their families. The hospital will provide services for a variety of needs—from routine medical appointments to highly unique specialties.

The facility will also serve as the military's premier facility for treating returning wounded service members.

Deputy Defense Secretary Gordon England said "The future medical facility will provide service members with the care they need and deserve. Families of those injured in combat are important to the recovery process and can now rest assured their loved ones will receive the best possible care available. Our warriors are our country's most important resource and when they return injured or ill from war, we must care for them without fail. Those who have earned our freedoms for us are guaranteed the best care and benefits."

Bush turned the shovel just as another president did nearly 69 years ago to the day. President Franklin Roosevelt and other officials began the initial construction on 29 June 1939.

Bush said he was proud of the steps military medicine has taken to ensure the treatment and care of the wounded during a time of conflict. The future center will be host to a variety of remarkable healthcare advancements and research, he said.

"I'm so honored to be here...for what is a grand occasion, the breaking of ground of a new joint medical facility for the men and women of our armed forces," Bush said. "With this new center, wounds will be healed, medical knowledge will be advanced, lives will be rebuilt, and those who wear our nation's uniform will be reminded they have the enduring gratitude of the American people."

Bush said the care givers treating those injured in combat are essential to the overall mission of the U.S. in the war on terrorism. Treating the wounded is not always as easy as it sounds, he said, as specialty care is also a big part of the healing process.

"Our nation is engaged in very different battle for our freedom, yet our success still relies on these anonymous

heroes, the healers who care for the troops," Bush said. "Giving our troops the care they deserve requires cutting edge medical facilities and that's what this new facility will provide."

Bush recognized Air Force SSGT Scott Lilley, who had been critically injured in Iraq, on his recovery and the care he received at the National Naval Medical Center.

He recalled meeting Lilley in the Oval Office not long after his injury and the president said he didn't think the airman would survive. Lilley's strength, determination, and his health care provider's aggressive treatment, however, were vital to his recovery, Bush said.

"Thanks to the extraordinary care at Bethesda, as well as his own, he is now back on active duty," Bush pointed out. "Their perseverance has paid off and so has his. Our wounded warriors show why the human body is fragile, the human spirit is strong."

Lilley said he was honored to have Bush mention his recovery during his speech. He said combining the medical expertise from National Naval Medical Center and Walter Reed Army Medical Center will form an unparalleled hospital.

Joint Task Force National Capital Region Medical Commander RADM John Mateczun said the new facility will mirror the existing buildings around the hospital to preserve the history and image of the original construction. The new facility will be home to some of the best care in the world, he said.

"The exterior design of the medical center will be in keeping with President Franklin Roosevelt's vision of what the nation's premier military medical center should look like," Mateczun said. "While the walls on the outside reflect the medical center's historic significance, the inside will house the most state-of-the-art medical resources in the world." 

—Story by HN Dustin Perry, National Naval Medical Center Public Affairs.



President of the United States, George W. Bush, and other Department of Defense officials break ground for the new Walter Reed National Military Medical Center during a ceremony at the National Naval Medical Center, Bethesda, MD. Photo by TSGT Jerry Morrison, USAF

## FULL VIDEO URODYNAMICS SUITE MAKES NAVAL HOSPITAL A “UNIQUE” FACILITY

Naval Hospital Pensacola has made major leaps recently in order to provide the most up-to-date and least painful, minimally-invasive urologic procedures available today. “We are unique,” said LCDR Timothy Redden, being the “only facility in the immediate area to have a full Video Urodynamics Suite” that helps in the diagnosis and treatment of a wide variety of urologic disorders such as the diagnosis and treatment of incontinence, pelvic organ, and bladder dysfunction.

NH Pensacola now offers minimally-invasive advance laparoscopic urologic procedures to treat benign and malignant diseases, and provides the “newest minimally-invasive treat-



LCDR Redden performs surgery at Naval Hospital Pensacola.  
Photo by MC1(AW) Russ Tafuri, USN

ment” for female pelvic floor dysfunction, incontinence, and prolapse, said Dr. Redden.

“Within the next few months, Navy urologists—at civilian partner Baptist Hospital Pensacola—will be performing robot-assisted, minimally-invasive radical prostatectomy in the treatment of prostate cancer,” he continued.

The robot-assisted treatment for prostate cancer removes the prostate and lymphatic tissue via several, less than one-half inch incisions using a DaVinci robotic system from intuitive surgery.

Navy urologists, Kevin Mahaffey and Redden, will be performing the surgeries for Department of Defense eligible patients at Baptist Hospital.

This “new beginning” for NH Pensacola urology, and the co-venture between the Veterans Administration and Defense Department with the soon to open Joint Ambulatory Care Center (JACC), will “allow the Navy medicine facility to

treat VA eligible veterans as well as active duty and retired DOD members and their families,” said Redden.

The joint venture will eliminate the need for some VA patients to have to travel long distances for treatment.

The minimally invasive surgeries allow for shorter hospital stays, shorter recovery, less pain, and a return to work sooner than traditional open surgery, the urologist continued. 

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

## NMCS D STANDS UP TO HELP HOMELESS VETERANS DURING ANNUAL STAND DOWN

More than 160 staff members from Naval Medical Center San Diego (NMCS D) took time to volunteer their services 11-13 July at Veterans Village of San Diego’s 21st annual Stand down.

Stand Down is a grassroots, community-based intervention program designed to help the nation’s estimated 200,000 homeless veterans. according to the organization’s website. NMCS D took the lead in providing medical services to the hundreds of veterans who turned out for the event, providing independent duty corpsmen, pharmacy technicians, administrators, and experts in preventive medicine, said Stand Down medical coordinator Tony Carvajal. “We start planning about 6 months in advance for the actual event,” said Carvajal. “I will meet with Veterans Village and see what they’re looking for in terms of support, and then I’ll take that info and start coordinating with the Navy.”

HMCS(FMF) Emmanuel Evangelista, NMCS D volunteer coordinator, said this was his first year participating in the Stand Down. “I was overwhelmed by the response I received to getting volunteers,” Evangelista said. “Sailors from all over the city wanted to participate; I was just in awe.”

NMCS D staff provided medical services including dental and vision services to the veterans. Carvajal said that volunteers administered approximately 150 dental exams and performed more than 90 tooth extractions over the course of the weekend.

“You see a lot of guys walking around with cotton in their mouths, but it’s usually the only time all year they get to see a dentist,” said Carvajal.

Also, more than 300 pairs



Homeless veterans line up outside the medical tent to see volunteers at the Veterans Village.  
Photo by MC2 Alexander Ameen, USN



**Volunteers help process paperwork for homeless veterans seeking medical treatment.**

Photo by MC2 Alexander Ameen, USN

of specially-designed glasses were given to veterans who received them at no charge. “The Navy really does a lot. Between dental and vision alone, we really depend on

them to help us out each and every year,” Carvajal pointed out.

Senior Chief Personnel Specialist (SW/AW) Marco Vallido, NMCS D volunteer coordinator, said the Stand Down was an important opportunity for sailors to participate in public service for the community. “For me, this kind of work brings a personal satisfaction,” Vallido went on. “I just want to give back to the veterans who sacrificed so much for me. I don’t need anything other than that.”

To learn more about Veterans Village of San Diego, visit their website at [www.vvsvd.net](http://www.vvsvd.net).

—Story by MC2 Alexander Ameen, NMCS D.

## BUMED FINANCIAL MANAGEMENT TEAMS RECEIVE AWARDS

Two financial teams at the Bureau of Medicine and Surgery have been acknowledged for their unique contributions to the mission of healthcare by improving business process and streamlining financial management. Navy medicine is not a business, but it is important to understand the business processes that contribute to Force Health Protection, the primary mission of Navy medicine.

The Bureau of Medicine and Surgery’s (BUMED) Financial Policy and Internal Controls (M82) team and the Financial Improvement Program (FIP) Team each received an award from the Office of the Assistant Secretary of the Navy (Financial Management and Comptroller) for streamlined business practices. The awards were presented at the American Society of Military Comptrollers Professional Development Institute conference held in Orlando, FL, 27-30 May.

“By receiving these awards, Navy medicine is setting the example for the rest of the Department of the Navy in how they conduct their business practices,” said Dave Howell, M82 team leader, and FIP team member. “These awards, along with the work we do everyday, show Navy medicine is leading the Navy in its efforts to create clear, effective, and efficient business practices.”

The M82 Team developed better ways to manage Navy medicine’s travel card and purchase card programs for 16,000 cardholders that cover nearly \$200 million in annual travel and over \$850,000 in purchases.

FIP’s Team focused on audit readiness by creating a better financial accountability process and providing a more complete financial view of the business of Navy medicine. This big picture view focused on identifying business processes at over a dozen medical centers and hospitals and includes a broad spectrum of details such as patient check-in procedures, property acquisitions, and civilian payroll. One very positive result of this effort was to change from a dual system to a single system for personal property accountability. That effort alone allowed Navy medicine activities and personnel to better recognize efficiencies in personal property tracking and management while reducing the information technology footprint of duplicate systems. And equally important this has aligned Navy medicine with Air Force and Army medical commands in the tri-service environment of the Military Health System.

The M82 team, led by Howell, includes team members Rosemarie Paradis, John Barnish, Freda King, and Eric Egger. The FIP Team includes LT Rebecca Lenher, MSC (FIP Lead), Melvin Becker, and Howell. The awards were presented during the American Society of Military Comptrollers (ASMC) Professional Development Institute (PDI) conference held in Orlando, FL, 27-30 May. ASMC is a non-profit educational and professional organization involved in the overall field of military comptrollership.

—Story by Christine Mahoney, Bureau of Medicine and Surgery Public Affairs.

## VA ANNOUNCES ONLINE CLAIMS APPLICATIONS

The VA now will accept online applications from veterans, survivors, and other claimants filing initial applications for disability compensation, pension, education, and vocational rehabilitation and employment benefits without having to submit a signed paper copy of their application.

No claimant signature is required for initial online applications received through the Veterans Online Applications (VONAPP) website. This electronic application is sufficient authentication of the claimant’s application for benefits. Normal development procedures and rules of evidence still apply to all VONAPP applications.

View a list of Frequently Asked Questions to learn more about VONAPP. Or, for more information about VA benefits, visit the VA’s website at [www.va.gov](http://www.va.gov) or call their toll-free number at (800) 827-1000.

## INTERN GRADUATION AT NAVAL MEDICAL CENTER PORTSMOUTH

The intern class of 2008 graduated at Naval Medical Center Portsmouth 27 June on the granite steps of Building 1. This year's class was composed of 72 Navy interns and 1 Air Force intern. "In a military that is moving more and more toward joint force operation, it is really important to learn other cultures," said CAPT Rebecca Christi, USAF. Christi will apply her service in the pediatric field.

LT Melissa Buryk was named Pediatrics Intern of the Year, Emergency Medicine Intern of the Year, and Overall Intern of the Year in a rare trifecta. "There are so many wonderful people in my class that could have won those awards, so I'm honored to be selected," said Buryk.

The Navy doctors will accept assignments ranging from flight surgery to undersea medicine. Fourteen of the Navy docs will have the opportunity to provide Marines healthcare from forward-deployed locations as they accept assignments to various Marine Corps units.

"This class is a great sign for the future and what it has in store," said guest speaker CAPT Michael H. Anderson, Deputy Medical Officer of the Marine Corps. "Now it is up to you to preserve the trust, demonstrate the courage, and strive to exceed your obligations."

As first-year medical officers, they have completed internship training in internal medicine, obstetrics and gynecology, orthopedics, otolaryngology, pediatrics, psychiatry,

surgery, and the transitional year programs. Unlike civilian programs, NMCP's interns are trained to be naval officers as well as physicians. They complete a rigorous program of general medical training to support the nation's

***"You represent military medicine, this hospital and this nation," said NMCP and Navy Medicine East Commander RDML Matthew Nathan. "Those that have served before you would be proud."***



LT Melissa Buryk receives the Navy and Marine Corps Achievement Medal from NMCP Commander RDML Matthew Nathan during the 2008 NMCP Intern Graduation Ceremony.

Photo by MC2 William Heimbuch

military forces around the world.

"This program trains us well...with-in our respective disciplines but also overall to take care of Navy medicine," said Buryk. "It trains us to be equipped to handle the stresses that we'll face out in the fleet."

The Intern Specialty Leader, CDR Edward Simmer, received special recognition for his service to the Graduate Medical Education program in antici-

pation of his pending summer transfer. "Not only was this my last class, but it was the best," said Simmer.

Begun in 1935, NMCP's intern program is the oldest medical training program in the Navy.

**—Naval Medical Center Portsmouth, VA, Public Affairs.**



Members of Naval Hospital Bremerton Puget Sound Medicine Residency program pose for a group image before their Family Medicine Resident Graduation Ceremony on 27 June. Six 3rd year residents shipped out to other various duty stations: LT Gregory J. Anderson, transferred to USS *Ronald Reagan* (CVN-76); LT Kenneth M. Fechner, II, has reported to U.S. Naval Hospital, Okinawa, Japan; LCDR Todd A. Gardner, reported to USS *Emory S. Land* (AS-39); LT Lachlan I. Munro's next duty station is still pending; and LT Daniel J. Sengenberger, reported aboard USS *Abraham Lincoln* (CVN-72). Five 1st year residents will continue their training at Bremerton. Photo by HM1(SW) Julie

Jorgensen

## THE WARRIOR RETURN UNIT—UNLIKE ANY OTHER

A soldier from the forward operating base in Talil suffers an appendicitis attack. A Seabee in Baghdad shatters his ankle. They are placed in the MEDEVAC system and sent by helicopter to Expeditionary Medical Facility Kuwait (EMFK) for care. Both go through surgery and inpatient care and are now ready for discharge but not ready to return to their unit. Neither can go home for a comfortable period of convalescent leave. What are the options?

Enter the Warrior Return Unit. Located on Camp Arifjan, Kuwait, its mission is to maximize the quality of life for coalition forces during the period of convalescence, expediting return to duty or transfer to definitive care. The Warrior Return Unit (WRU or “Roo”) is a three-building complex dedicated solely to the purpose of providing a place for service members to live, relax, and heal from their illnesses, injuries, or surgical procedures and, ideally, return to duty. In addition to comfortable living accommodations, the WRU also provides a full entertainment lounge, DSN lines for business or morale calls, gaming stations, and internet access, as well as 24-hour staffing, with an RN onsite and dedicated transportation to and from the hospital.

The WRU has been evolving since 2005, and is always looking for ways to improve. A current construction project involves relocation of the physical therapy (PT) department to a large and convenient space within one of the WRU buildings. Most WRU residents are recovering from orthopedic injuries, so placing PT close by is quite advantageous. In addition, the new design triples the available PT space and thus benefits the entire command. Other current WRU improvements include construction to provide semi-private three- to four-person rooms in areas that were previously open bay berthing. The Commanding General USARCENT and his staff visited the WRU in March 2008, noting the important role it played in keeping soldiers and sailors close to the fight but allowing them to heal from their various medical and surgical conditions. CAPT Elaine Wagner, commanding officer of EMF-Kuwait agreed: “The WRU represents why we’re really here and what we do. To keep soldiers, sailors, airmen, and Marines as close to the fight as possible and get them back to their units as quickly as we can.”

While not everyone can return to the fight, approximately 80 percent of all wounded warriors do indeed return to duty from the WRU and almost 75 percent of them return directly back to Iraq. The WRU works closely with commands and the EMFK Patient Administration Department to ensure that personnel unable to return to duty are appropriately medevaced to tertiary care centers in Landstuhl, Germany or CONUS, keeping the average length of stay in the WRU

between 8-10 days. Any time a service member is moved out of theater, the medevac system has the potential for a variety of delays, including travel times, appointments with specialists, and lack of oversight, all of which can prevent a member returning promptly to duty, leaving the units on the frontlines short of personnel.

The WRU averages 50 residents any given day. However, it has the capacity for 104 beds for males and 32 beds for females, and has recently reached a census of up to 70. The eight member staff also reside at the WRU, providing a true 24/7 service concept.

Residents of the WRU also benefit from the other services of EMFK. While convalescing, many exercise self-referral for PT, the chaplain’s office, and mental health. “Several residents were able to address significant mental health needs even though they were here for other reasons. This allows us to catch things that may have become problematic later down the line,” says LTJG Porras, of the mental health clinic. The WRU also provides the “warm and fuzzy” feeling for units on the front-line. Speaking to the Marine Corps Patient Administration Tracking Team, located in Kuwait City, frontline units know that the WRU provides their people with a safe place to convalesce without the risk of losing them to the medevac system. In this aspect, the WRU is more than a “med hold” for the hospital. It is a convalescing way station for units all over the combat theater serving all the coalition forces. ⚓

—Story by LCDR Dan Clark, Head, Warrior Return Unit, EMF-Kuwait.



LCDR Dan Clark and HN Antuneztrevino provide onsite wound care.



Patients are provided a milieu conducive to recovery in common lounge of the Warrior Return Unit. Photos courtesy of LCDR Clark

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## NAVY MEDICINE SCIENTIST TO HEAD NEW JOINT INFECTIOUS DISEASE PROGRAM

A research scientist at the Naval Medical Research Center (NMRC) in Silver Spring, MD, was selected as the research coordinator for the new Military Infectious Diseases Research Program's (MIDRP) Wound Infection Program.

CDR Kyle Petersen, undersea medical officer, is assigned to the NMRC Combat Casualty Care directorate where he performs undersea medicine research and also provides patient care at the nearby National Naval Medical Center (NNMC) at Bethesda.

The MIDRP Antimicrobial/Wound Infection Program, a Department of Defense joint multi-service effort, will develop and evaluate devices, technologies, and treatments to prevent and treat infections in combat casualty injuries. While work in these areas is ongoing, the program will officially begin in fiscal year 2010. Potential areas of investigation include bacterial pathogenesis and colonization of wounds, investigation of topical antimicrobial agents, and investigation of antimicrobial synergy.

"I'm very excited," Petersen said. "This is a fantastic opportunity to deliver even better evidence- and science-based care to our men and women in uniform who have given so much and been wounded in service to their country."

The new program was created in response to new types of wound infections being found in injured combat troops returning from Iraq and Afghanistan, said CAPT Vincent DeInnocentiis, NMRC executive officer. Many of these infections are very difficult to treat and are resistant to current antibiotics and other traditional treatments.

With Petersen's selection, there are 11 MIDRP research coordinators leading the joint efforts of approximately 300 Army, Navy, Air Force, DOD civilians, and contract scientists located in eight infectious diseases research laboratories. Approximately 2,000 support personnel are also assigned. The eight MIDRP major infectious diseases research laboratories are located in Maryland—Naval Medical Research Center, Walter Reed Army Institute of Research, United States Army Medical Research Institute of Infectious Diseases—and overseas in Peru, Egypt, Kenya, Thailand, and Indonesia with smaller detachments in Nepal, Uganda, Tanzania, Nigeria, Cameroon, and Ghana.

Petersen said Navy military treatment facilities (MTFs) will be involved in some of the clinical research and will bene-



fit from the basic science research as it transitions to the clinical setting. Other Navy involvement will come from NMSC laboratories involved in the basic science research effort.

Petersen is board certified in internal medicine and infectious diseases, and trained at Naval Medical Center San Diego. He is the author of numerous scientific abstracts and manuscripts concerning wound infection with multi-drug resistant pathogens. Petersen said he will continue patient care at NNMC Bethesda and undersea medicine research at NMRC while beginning preliminary work for the MIDRP.

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

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## STEERING CORPSMEN ON THE RIGHT COURSE

When HMC John Kelly was assigned to a frigate, he found out a young hospital corpsman had orders to the ship. The addition would certainly add to his understaffed medical department. When the corpsman in question reported to duty, it was with minimal experience and nominal background in a Navy sick call setting.

Kelly, along with a host of other Naval Hospital Bremerton CPOs, wanted to ensure that scenario doesn't happen again.

The NHB HMCs began their pilot Operational Hospital Corpsman Course with pronounced emphasis and practical application on Navy sick call screening procedures.

"Our objective is to provide the necessary introductory sick call training to our corpsmen," explained Kelly. "Going through this training will make them more qualified and more valuable when they reach the fleet."

According to Kelly, when an HN gets to an operational platform, whether it's aboard ship or with the Marines in the field, the entire command is dependent on that corpsman being able to evaluate and treat sailors and Marines in a sick call setting.

"We will enhance current clinical competencies and build on their core corpsman training," said Kelly.

The course includes such topics as anatomy and physiology, patient history, pharmacy, minor procedures, and physical exam and diagnosis. The corpsmen attending the course will learn how to recognize, deal with, and treat some of the more common sick call concerns such as minor headaches, uncomplicated upper respiratory infections, minor musculoskeletal problems, minor surgical procedures, suturing minor wounds, toenail removals, minor incision and drainage, and minor dermatological conditions.

"I really like the training," said HM3 Leonard Thomas, course attendee. "My next duty station is with First Marine Air Wing, Okinawa, and my learning here is going to be applicable in that setting."



**A stitch in time: HMC John Kelly demonstrates suture techniques to HN Lev Castillo.**  
Photo by Douglas H. Stutz

Thomas stated that the goals he hopes to get from the course are to learn the basic foundations of sick call, to be able to examine a patient properly for presentation to a medical officer, and to gain clinical experience.

Suturing minor wounds was one procedure that gave the corpsman students hands-on application practice. "Suture techniques are a necessity for any corpsman in any operational environment," explained Kelly. "A corpsman has to know not only how to suture, but also what doesn't require a suture. Our training here will give corpsmen the know how to handle and treat an abrasion, incision, laceration, or puncture wound."

"With practice, training, and knowledge, there is no problem they won't be able to handle in the future," continued Kelly. "Step by step, we're setting them up for success in dealing with their people." ✍

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

## NAVY ETT MENTORS ANA CLINIC STAFF

With some small changes to organization and some forward thinking, a Navy Embedded Training Team (ETT) and an Afghan National Army (ANA) clinic staff, serving the ANA 205th Corps, 1st Brigade, have improved operations and can provide better care for patients.

Nearly a year and a half ago, 10 metal containers were welded together to form the original medical clinic at Forward Operation Base Lindsey, where the ANA medical staff of nine treated 60-80 soldiers a day. With help from a Navy ETT, the ANA staff completed a reorganization project. Today the Afghan staff treats the daily influx of soldiers more efficiently.

LCDR Jerry Haywald, senior medical mentor, said on his first visit to the clinic, he had to compete with close to 50

patients inside a waiting area, half the size of a typical waiting area.

"The head doctor's office was in chaos," Haywald said. "Daily, his desk was being swarmed by patients due to the small, insufficient waiting area."

Haywald, LTJG Brettson Platte, and MSGT Cynthia Williams, USAF, all ETT members, sat down with the ANA staff and discussed alternative layouts for the clinic. They agreed on changes to help increase access to care by improving the patient registration process, the waiting area and patient evaluation space.

The changes included building an awning outside for shade and adding benches underneath to serve as a waiting area. The pharmacy was moved to an area previously used for sleeping, converting the vacated space into a second patient evaluation room. Two walls were added to the treatment areas to give patients more privacy.

"The ANA staff redesigned the registration area by adding new filing cabinets and installed a registration computer workstation to record patients' statistics," Haywald said.

Recently, the ANA has started using patient medical records for tracking patients' visits, injuries and medical history. "We have advised the providers (Afghan clinic staff) that proper documentation is important and will help them with future diagnoses," Haywald said. "They were reluctant at first, however, they are beginning to see the benefits."

The service members mentored the staff on how to use a new computer tracking program and are training the ANA pharmacy personnel on a computerized program used to order supplies. "This system has resulted in better accountability, legible documentation, and quicker actions regarding supply requests," Haywald said.

Abdul Rahman, head physician for the clinic, said the renovations and training have helped him run the clinic smoothly and provide better, more efficient care to his patients.

The mentoring team has high hopes for the future of the garrison medical clinic. Haywald said the improvements are helping them toward the goal of a completely Afghan-led clinic in which the ANA work and operate on their own. ✍

—Story by SSGT Beth Del Vecchio, USAF, *CSTC-A Public Affairs.*



**LCDR Jerry Haywald (left) watches as an ANA physician's assistant checks a patient's vital signs.** Photo by SSGT Beth Del Vecchio, USAF

## TEAM SUPPORTS RECONSTRUCTION OF AFGHAN HEALTH SYSTEM

Like most of Afghanistan's provinces, Konar has historically been unable to meet the medical needs of its 381,000 residents. But the Konar Provincial Reconstruction Team (PRT) is working to meet those needs. As recently as 2002 and shortly after the departure of the Taliban, Afghanistan has faced some of the worst health statistics ever recorded worldwide, including an infant mortality rate of 16.5 percent and 1,600 maternal deaths for every 100,000 live births. More than 25 percent of Afghan children die before their 5th birthday.

In Konar, nearly 60 percent of the population lacked access to any form of health services. The Konar PRT is one of 12 U.S. led partnership organizations working with the Afghan government to rebuild the healthcare system and improve medical services.

LT Gregory Monk, a Konar PRT physician assistant from Naval Hospital Camp Pendleton, CA, has managed much of that work in the province. His team of corpsmen includes HM2 Alexander Tabayoyon from Naval Air Station Fallon, NV, HM2 Ixchel Mattes from Naval Hospital Bremerton, WA, and HN Leo Cedeno from Branch Clinic China Lake, CA.

Monk and his staff work closely with the provincial health director, Dr. Asadullah Fazli, to assist in the implementation of the Basic Package of Health Services (BPHS). The BPHS is an Afghanistan Ministry of Public Health strategy to provide a standardized package of basic health services. The ministry, Dr. Fazli, and Aide Médicale Internationale (AMI), with input from the PRT, use the BPHS to identify districts with under-served populations and determine the location for new facilities.

AMI is an apolitical French humanitarian organization that implements healthcare networks around the world. The strategy was designed to increase access for people more than 2 hours' walking distance from public health ministry facilities. After selecting the locations for the clinics, Monk works with PRT engineers to solicit contract proposals and oversees the quality of construction for the new buildings. Once the building is constructed, AMI acquires the staffing, professional medical training, and supplies needed to run the clinics.

With the assistance of the PRT, 15 new healthcare facilities are being added to the province. Fazli reported that 6 years ago, the Konar health network consisted of only 12 low-quality clinics. Now, the province has 24 healthcare facilities—one provincial hospital, nine comprehensive health



**LT Monk conducts a medical outreach visit in the Chowkay district of Afghanistan's Konar Province.** Photo by LT Neil Myers

clinics, and 14 basic health clinics—and an additional 242 basic health posts.

Assisted by Afghan doctors, the PRT medical team conducted village medical outreaches in the remote regions of Konar where local clinics do not exist. On missions into the local communities, they have treated Afghans for a variety of ailments. According to Monk, worms and other intestinal illnesses were the main ailments afflicting most of the people the team treated.

The community uses the Konar River, which flows through the province, for everything: drinking, cooking, bathing, hygiene, and even recreation. But the river is heavily contaminated with pathogenic bacteria, parasites, and viruses. Monk said almost everyone he sees for evaluation complains of stomach pains. "The stomach pains are commonly caused by worms or other parasites, but chronic conditions, such as reflux disease, are just as common," Mattes explained. "Education on simple acts of washing hands and boiling water before use can prevent a majority of these illnesses."

The regular engagements became less common, thanks to the growing number of clinics and local doctors in the villages. "It makes you feel good to go out and assist Afghan doctors in remote villages that have zero access to medical treatment," Monk said. "We hope that one day every community has its own clinic, ultimately becoming less reliant on these outreach missions." ✍

**—Story by LT Neil Myers, Konar Provincial Reconstruction Team and American Forces Press Services.**

## IRAQI PARTNERSHIP EXTENDS TO OR

Iraqis are no longer just patients in operating rooms, now they are scrubbing-in alongside their U.S. counterparts to participate in surgeries. Camp Taqaddum Surgical, 1st Supply Battalion (Reinforced), 1st Marine Logistics Group, has partnered with Iraqi medical personnel at Camp Habbaniyah and brought them into the operating room.

LCDR John A. Lynott, senior orthopedic surgeon with TQ Surgical, worked with Iraqi Army MAJ Tahseen Muallah, medical officer from Camp Habbaniyah, to remove fragments from the leg of an Iraqi policeman.

Mohammed Ali, the 33-year-old policeman, was injured by an improvised explosive device in 2006. Since then, his injuries have prevented him from being a policeman and keep him up at night.

With the help of a portable x-ray machine, the two surgeons worked together to remove the fragments and get him back in the fight. Even with the x-ray machine, the process is still very similar to searching for a needle in a haystack.

“The body recognizes the foreign objects so it wraps around them, making it hard to dig out,” said LT Rich O’Kane, an orthopedic physician’s assistant with TQ Surgical. This didn’t stop the two surgeons who had made a commitment to their patient.

“I told him I’d get (the fragments) out but I wouldn’t take half his leg to find it,” said Lynott.

Less than 2 hours later, the fragments were removed and Ali was recovering from the surgery.

“It’s the first time we’ve scrubbed in with any Iraqis,” said Lynott, who felt confident in Muallah’s abilities and noticed how well-trained he was in the operating room.

With progress like this, it’s only a matter of time before the new medical facility at Habbaniyah is up and running, staffed with well trained and experienced Iraqi surgeons.

“The idea is to someday get to the point where we can (help them with surgeries) in their space,” said CAPT Ted P. Briski, the commanding officer of TQ Surgical. Once that is accomplished, the Iraqis will soon be able to handle



**LCDR Lynott points out the embedded fragments in an Iraqi Policeman's leg to Iraqi Army MAJ Tahseen Muallah.** Photo by CPL Tyler B. Barstow, USMC

everything on their own. “The goal is to eventually step even further back into the background,” he said.

Both sides see the benefits as the relationship continues between the two forces. “Anything we do to help build their medical capacity is a good use of our time and facilities,” said BGEN Robert R. Ruark, commanding general of 1st Marine Logistics Group.

Given a little more time and some experience with the facilities here, the Iraqis will soon be treating their own, thanks to this partnership. ✍

—Story by CPL Tyler B. Barstow, USMC.

## TRAILER TOWN BENEFITS FROM A COOPERATIVE MEDICAL ENGAGEMENT

A combined medical engagement was held by Marines and sailors of the 1st Marine Logistics Group (MLG). Three corpsmen from 2nd Low Altitude Air Defense (LAAD) and 1st Supply Battalion (Reinforced), 1st MLG, assisted in triage, assessing patients, and prescribing medications. Trailer Town is a poor neighborhood in Kabani, Iraq. Chest pain, abdominal pain, headache, and sore throat were some of the most common complaints. “The care my son and I received was excellent,” said Salam A. Khalfa, a local resident. “Before, we didn’t have any medical care, but now that we were visited by the Navy and Marines, we have medicines to take care of our families.”

Healthcare and medical supplies were distributed to the locals. Preventive care and medicines were a major part of the engagement. Iraqi police, along with Marines with Bravo Battery, 2nd LAAD Bn., provided security for the mission.

Sixty-five Iraqis were seen during the visit, 55 percent of those patients were pediatric, 35 percent were adult males and 10 percent were adult females. This engagement was a continuation of a Combined Medical Engagement in Kabani which helped more than 130 Iraqis. In all, approximately 200 Iraqis were treated. ✍

—Story by LCPL Robert C. Medina, USMC.



**HM3 LaSahon P. Washington palpates the abdomen of an Iraqi child.**

Photo by LCPL Robert C. Medina, USMC

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## HERE COMES THE STORK

Children often are told that the stork delivers babies, but the miracle of birth is far more involved. For military families, dad is often absent because he's at sea, in a war zone, or serving his country somewhere far away.

When that happens, the stork doesn't bring the baby, but Naval Medical Center Portsmouth's Stork Cam delivers a photo of the new baby to dad, wherever he may be. And it's not just for Navy fathers; patients are affiliated with all services of the military.

Operation Stork Cam is a collaboration between the hospital's Mother-Baby Unit and the Public Affairs Office (PAO) to ensure that deployed dads get a picture of mom and baby soon after delivery. PAO staff take a digital photo of the infant and email it along with the baby's vital statistics to the father, usually within 2 days after the birth. The Mother-Baby Unit staff alerts PAO, and mom provides dad's email address.

The Portsmouth Stork Cam has been delivering photos for some 10 years. Over the last 3 years, photos of newborns have been delivered to more than 150 deployed fathers, at sea and downrange. As long as dad has an email address, he can get pictures of his new baby.

"It's good because my husband wouldn't get to see pictures of the baby until I get him home, and sometimes you have to stay in the hospital for awhile," said Tanya Wood, EN2 Stuart Wood, is currently deployed to Afghanistan. He is the latest service member to get a special delivery from the Stork Cam. ✍

**—NMCP Public Affairs Press Release.**



**Tanya Wood with son Sebastian Amedaus. Wood's husband, EN2 Stuart Wood, is currently deployed to Afghanistan. Photo by MC2 William Heimbuch, USN**

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## NURSE CORPS HISTORY ON DISPLAY IN PORTSMOUTH

Fifty-three years ago, Rose Mary Maul answered the door at the Nurses' Quarters at Bethesda Naval Hospital. Back then, she was LTJG Rose Mary Clemens, whose grandfather's cousin was Samuel "Mark Twain" Clemens. The visitor gave her something that has now become part of Navy nursing history at Naval Medical Center Portsmouth.

When Maul opened the door, the visitor asked her, "Are you a Navy nurse?" "And I said, 'Yes, I am.' She said, 'I want to give you something. It's a Navy nurse's cape.'"

The woman at the door was a retired Navy nurse, and she wanted to pass along her 1913 uniform cape to a fellow Navy nurse. Maul remembers the day well—13 February 1955—because she wrote it on the garment label inside the cape. For the next 15 years until she retired, Maul wore the heavy wool cape through tours at Bethesda, Portsmouth, Philadelphia, Great Lakes, and on MSTS (Military Sea Transportation Service) Atlantic runs. The MSTS later became the Military Sealift Command.



**Rose Mary Maul poses with the famous cape. Photo NMCP PAO**

"That cape got me through many cold winters, especially aboard ship. Do you have any idea how cold it is in the North Atlantic with the ice floes up around Greenland?" she reminisced.

Maul spent 20 years as a Navy nurse and retired in 1970 as a lieutenant commander. She married and returned to the Norfolk area. In all those years, she cherished the woman's gift and started thinking about passing it down to another nurse who would appreciate the cape as much as she had.

Maul was at a Nurse Corps Association meeting last year and struck up a conversation with CAPT Karen DiRenzo, a fellow Navy nurse, who suggested putting the cape on display. The long black cape is now housed in a glass case in the NMC's Portsmouth crew library.

DiRenzo returned to Portsmouth from her new duty station at Naval Health Clinic New England to join Maul for the presentation. DiRenzo said, "It's great to be able to preserve Nurse Corps' history." Maul agreed. "I was stationed at Portsmouth from '62 to '66, and now [the cape is] right back here. I didn't want someone to take it and put it in a thrift sale."

That's not going to happen. With 2008 marking the 100th birthday of the Navy Nurse Corps, this piece of Navy nursing history will be treasured and appreciated for years to come. ✍

**—Story by Deborah Kallgren, Naval Medical Center Portsmouth Public Affairs.**

## FROM BREMERTON TO BAGHDAD

Most Trauma Centers have a tendency, as the name suggests, to be chaotic, hectic and frenetic. Saving lives, treating the injured, and mitigating pain in multiple and on-going emergency situations is the reality in any trauma setting. Even more so when assigned to a Trauma Center in Iraq, as LCDR Constance Hymas, NC, Naval Hospital Bremerton's Department Head for Staff Education and Training was during her recently-completed deployment.

Hymas utilized her Navy Nurse Corps skills in serving as Trauma Nurse Coordinator on an 11-person Joint Theater Trauma System (JTTS) team, working at Ibn Sina Hospital, located inside the Green Zone of Baghdad, Iraq. Surrounding urban warfare in the city continues to bring a steady stream of bomb, bullet, and blast victims. She also handled the daily increased need to compile precise documentation to understand current and future casualty trends and necessary pending medical support. "Our primary goal there was to ensure the right patient had the right care, at the right place, at the right time," said Hymas.

Ibn Sina is nicknamed "Baghdad ER." It is one of Iraq's busiest trauma centers. The hospital was the focus for an HBO documentary film which showed the Army medical staff there during the spring and summer of 2005 treating wounded troops. Ibn Sina's Trauma Center is staffed with Joint Force personnel under Army command who are equipped to handle traumatic injuries with comprehensive emergency medical services around the clock.

Hymas' work days routinely started shortly after dawn and continued for a minimum of 12-24 hours and, many times, longer. The most common injuries were the result of improvised explosive devices (IEDs). IEDs and other similar booby-traps have a tendency to be indiscriminate. Besides injured Joint Forces service members, Iraqi Army and police personnel were treated, as well as locals in need of immediate care. "More than once we'd be working on a local child who became a casualty by just playing in the wrong place or picking up the wrong item," Hymas remembered.

According to Hymas, her work on the JTTS team continued to provide improved trauma care to patients, especially in such a battlefield environment. "Along with doing complete daily chart reviews of all patients, ensuring our care was the highest quality, and that our procedures were consistent with our guidelines, we also constantly compiled data for the Joint Theater Trauma Registry (JTTR)," said Hymas.

The JTTR is a data collection-center for all Department of Defense trauma cases. The data Hymas collected was then used to provide relevant and timely information on all aspects of trauma patient care and injury outcomes. It was further analyzed and evaluated to support the reduction of morbidity

and morality in military as well as civilian trauma patients. To date, JTTR data has proved instrumental in adding more protective plates on the Individual Body Armor (IBA), instituting modifications in applying tourniquets, and even instituting changes in blood transfusion procedures.

Despite being in the relative safety of the Green Zone, the steady casualty rate was a constant reminder of the war. The hospital was also a target of opportunity on occasion. During her 7-months in-country that began in mid-October, there was just one mortar round that landed nearby on Thanksgiving Day. But on Easter, the incoming rounds accelerated. "We had a barrage all day on Easter," said Hymas. "It was very heavy and the attacks continued. It did impact our lives. We obviously wore our IBA much more frequently, and of course more shelling meant more casualties."

Hymas attests that one of the most amazing experiences during her deployment, along with being able to make a positive difference, is the friendships formed with members of the other services and also with local nationals she worked with.

"I am very thankful I had the opportunity to help over there. It was a great experience," said Hymas. "I also have a much greater appreciation of life and liberty than I ever did. Life and liberty are really broken down to very basics. One day I put out some extra bottles of shampoo in a common-home. Several young Iraqi girls that worked with us came by to say thanks. They could not go out on their own and do such a common chore as shop for themselves because it was too dangerous. Their photos were even posted in a local mosque announcing they worked with Americans. There were also Iraqi men at the hospital who would not tell their family where they worked out of fear that a family member might be targeted for kidnaping."

As a Navy nurse, Hymas' career has taken her to the cold of Iceland for a tour of duty, and now the heat of Iraq for an Individual Augmentee deployment. From one extreme to the other, she has steadfastly continued to make sure that the right patient had the right care at the right place at the right time. ✍

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



LCDR Constance Hymas poses for a photo opportunity at Al Faw Palace which has been converted into one of the largest U.S./Coalition Force bases in Iraq. Photo courtesy LCDR Hymas

# PACIFIC PARTNERSHIP 2008

## U.S., PORTUGAL TEAM UP TO HELP YOUNG GIRL IN TIMOR-LESTE

Thanks to the members of Pacific Partnership 2008—specifically Portugal—one little girl reaps the benefits long after USNS *Mercy* (T-AH 19) sailed away.

Natalia Dos Santos, a 10 year old from Bartete, a small village outside Dili suffered from headaches for years, and her family did not know the cause until she visited a medical civic action program sponsored by Pacific Partnership.

She was treated at Nurlan 1 Primary School and diagnosed aboard *Mercy*. “I noticed she was really short for her age, and her eyes had see-saw nystagmus [a see-saw like motion of the eyes],” said LCDR Kathleen O’Mara, a general pediatrician “I consulted ophthalmology.”

Dos Santos arrived aboard *Mercy* for a computed tomography (CT) scan, which revealed a 3-inch by 3-inch mass in the center of her brain. The growing mass and problems Dos Santos experienced were only the beginning of a condition that could ultimately result in a severe neurological event or death.

“Here is a case of someone who really needs our help,” said O’Mara, who further explained that the young girl would need additional care following the Pacific Partnership stop in Timor-Leste.

O’Mara contacted the original doctor who brought Dos Santos to *Mercy*, Portuguese Dr. Paulo Grillo, a neurological endocrinologist at the Portuguese Embassy clinic.

“Her mother said she has had severe headaches since November and remembers when Natalia was six, she was shaking and foaming at the mouth—what I would describe as a seizure.” Grillo said.

O’Mara and Grillo worked together to provide the necessary assistance and care for Dos Santos.

“I contacted the Lisbon Hospital and sent the tests done by *Mercy*,” said Grillo. “In 2 hours they got back to me and said they would pay the way for her and her father to come to Portugal for her to have her surgery and the months of aftercare she would need.”

After working with the Lisbon Hospital, Grillo contacted the Ministry of Justice to get a passport for Natalia and her father and coordinated a United Nations flight to Portugal with the Portuguese National Guard in Timor.

According to O’Mara, the outlook for Dos Santos is good.



**Natalia Dos Santos checks aboard *Mercy* after being referred at a Pacific Partnership medical civic action program.**  
Photo by CDR Kenneth Kubis, USN

Working together in partnership to aid a member of a host nation exemplified the mission of Pacific Partnership. Timor-Leste was the third partner nation Pacific Partnership 2008 visited on its humanitarian civic assistance mission.

—Story by LTJG David Bennett, Pacific Partnership 2008 Public Affairs.



**CDR Michele Gasper examines a Micronesian child.** Photo by MC1 A. Nick De La Cruz, USN



**A woman and child wait to receive medical attention.** Photo by MC3 Derek R. Sanchez, USN



**LCDR Brian Prendergast, left, an entomologist and head of the preventive medicine department, and HM2 Edric Aquino, assemble a catch net on a light trap.** Photo by MC2 Greg Mitchell, USN

# CONTINUING PROMISE 2008

## MEDICAL CARE OFFERED TO REMOTE REGIONS IN NICARAGUA

Joint-military service members set up a 4-day medical clinic in Yulu, Nicaragua 19-23 August to provide remote medical care and education to the locals as part of Continuing Promise 2008.



LCDR Nathan Uebelhoer examines an abnormal irritation on a local Nicaraguan woman at the Juan Comenius High School medical clinic. Photo by MC2 Erik Barker, USN

“The medical needs here are the same as ours in America, but they are also different,” said LCDR Nathan Uebelhoer, MC. “Patients in America can be treated for small problems right away through self-medication, but here they don’t have that option.”

The lack of common pharmaceuticals in the rural community is the root cause and potential cure for many of the chronic illnesses in places like Yulu. “I have seen a lot of patients with Impetigo,” said Uebelhoer. “A simple antibiotic mixed with a proper diet would cure it within days normally, but because of the lack of treatment and nutrition it will take them much longer to heal.”

This brought volunteers to the next stage of empowering citizens of Yulu to live healthier lives, education about nutrition, diet and exercise. Proper nutrition is very important when you want to stay healthy. The immune system will take much longer to fight off an illness if a person is malnourished or does not have proper hygiene.

When *Kearsarge* departs from Nicaragua they will move forward with the Continuing Promise mission to Panama, Colombia, Dominican Republic, Trinidad and Tobago, and Guyana.

The Continuing Promise Caribbean Phase is the second of two humanitarian and civil assistance deployments to the Southern Command area of focus for 2008. The first Continuing Promise deployment was conducted by USS *Boxer* (LHD-4) in the Pacific.✍

—Story by MC2 Gina Wollman, *Continuing Promise Public Affairs*.



CDR Brian Alexander, an optometrist, checks on Ches Lacallo after surgery to remove an abnormal growth from his right eye. Photo by MC2 Erik C. Barker, USN



LCDR Nathan Uebelhoer shows a group of Nicaraguan children the pictures he has taken of them playing soccer. Photo by MC2 Gina Wollman, USN



CDR Angelia Elum-Oneal hands an Operation Smile patient to LCDR Maria Norbeck after a successful surgery. Photo by MCSN Joshua Adam Nuzzo, USN

## COMMAND CHANGES

### NAVAL HOSPITAL CAMP LEJEUNE, NC

**C**APT Gerard R. Cox relieved CAPT Mark C. Olesen as Commanding Officer Naval Hospital Camp Lejeune on 25 July.

CAPT Olesen returned to the Washington, DC, area and reported to Headquarters Marine Corps as the Deputy to the Medical Officer of the Marine Corps.

CAPT Cox most recently served as Executive Officer, U.S. Naval Hospital, Okinawa, Japan.

### NAVAL HOSPITAL NAPLES

**C**APT Joseph E. Saraschene relieved CAPT Dale M. Molé, as Naval Hospital Naples Commanding Officer.

CAPT Molé transfers to Bahrain where he will serve as the next 5th Fleet Surgeon.

CAPT Saraschene formerly served as Executive Officer, Naval Hospital Camp Pendleton CA.



### NAVAL MEDICAL CENTER PORTSMOUTH

**R**DML William Robert Kiser relieved RDML Matthew Nathan as the 72nd Commander, Naval Medical Center Portsmouth on 12 August. He also will serve as Commander of Navy Medicine East, which includes 14 naval hospitals and their clinics.

Nathan is now Commander of the National Naval Medical Center and Navy Medicine Capital Area in Bethesda, MD.

RDML Kiser most recently served as the Assistant Deputy Chief of Staff for Clinical Operations and Chief Medical Officer for Navy medicine in Washington, DC.

Nicknamed the “First and Finest,” Naval Medical Center Portsmouth has the distinction of being the nation’s first naval hospital. It has proudly served the healthcare and medical needs of the nation’s military continuously since 1830.



### CROSSING THE LINE” WITH USNS *MERCY* ON “DOT-MIL-DOCS”

**L**ive by satellite from East Timor, “Dot-Mil-Docs” hosted CAPT James Rice from aboard the Military Sealift Command ship USNS *Mercy*. Rice is commander of the Military Treatment Facility aboard *Mercy*. He talked about the humanitarian work performed by *Mercy* medical personnel as the ship carries American goodwill and healthcare to remote areas and disaster sites worldwide. Hosted by the Department of Defense. “Dot-Mil-Docs” broadcasts at [www.blogtalkradio.com/Dot-Mil-Docs](http://www.blogtalkradio.com/Dot-Mil-Docs).

In addition to the popular “Dot-Mil-Docs,” the MHS is increasingly engaging in “Web 2.0” to interact with the uniformed services community and the general public. The MHS website at [www.health.mil](http://www.health.mil) features debates, news, videos, an “ask the leader” section and the blog of Assistant Secretary of Defense for Health Affairs S. Ward Casscells, MD. For those having trouble accessing Blog Talk Radio, the most recent program is accessible through the video and audio section at [www.health.mil](http://www.health.mil)

To find out more information about “Dot-Mil-Docs,” and other programming features, please visit [www.blogtalkradio.com/Dot-Mil-Docs](http://www.blogtalkradio.com/Dot-Mil-Docs)



RDML Michael H. Mittelman is being assigned as Medical Officer, Joint Forces Command, Norfolk, VA. Mittelman is currently serving as Director, Medical Resources, Plans, and Policy Division, N931, Office of the Chief of Naval Operations, Washington, DC.



CAPT Elizabeth S. Niemyer, who has been selected to the rank of rear admiral (lower half), is being assigned as Director, TRI-CARE Region West, San Diego, CA.



RDML William M. Roberts is being assigned as Director, Medical Resources, Plans, and Policy Division, N931, Office of the Chief of Naval Operations, Washington, DC. Roberts is currently serving as Medical Officer to the Marine Corps, Headquarters U.S. Marine Corps, Washington, DC.

**H**N Dustin Kelby Burnett, 19, of Fort Mohave, AZ, died 20 June while conducting combat operation in Farah Province, Afghanistan. He was assigned to First Marine Division Detachment, Twentynine Palms, CA.



**H**M2 Anthony M. Carbullido, 25, of Agat, Guam, died 8 August in Sangatesh, Afghanistan, from injuries suffered when his convoy vehicle hit an improvised explosive device. He was assigned to the Naval Hospital Corps School in Great Lakes, IL.



**H**N Marc A. Retmier, 19, of Hemet, CA, died 18 June as a result of wounds suffered from an enemy rocket attack in northern Paktika Province, Afghanistan. He was assigned to the Provincial Reconstruction Team Sharana in Afghanistan.



### NAVY MEDICINE'S EXPERIENCE WITH THE MILITARY TO CIVILIAN CONVERSIONS

**S**tarting in fiscal year 2005 (FY05) through FY13, Navy Medicine programmed a total of 7,790 military to civilian conversions through three different initiatives. Effective 28 January 2008, the FY08 National Defense

Authorization Act established a prohibition on the conversions through FY12.

Learn more about the conversion history and plan for the way ahead in the November/December 2008 issue of *Navy Medicine*.

If you cannot wait until the next issue, then contact LCDR Robert Anders, MSC, USN, BUMED —12 at 202-762-3611 or robert.l.anderson@med.navy.mil

### SAILOR MISSING FROM THE VIETNAM WAR IS IDENTIFIED

**T**he Department of Defense POW/Missing Personnel Office (DPMO) announced that a U.S. serviceman, missing from the Vietnam War, has been identified. He is HM3 Manuel R. Denton, of Kerrville, TX. On 8 October 1963, Denton was one of six men who crewed a UH-34D Choctaw helicopter that was on a search-and-rescue mission. While over Quang Nam Province, Vietnam, the helicopter came under intense enemy ground fire and crashed. There were no survivors. Over the next several days, the remains of four of the crewmen were recovered, however the remains of Denton and one other crewman, U.S. Marine Corps LCPL Luther E. Ritchey Jr., were not recovered.



Between 1991 and 2000, several joint U.S./Socialist Republic of Vietnam (S.R.V.) teams, led by the Joint POW/MIA Accounting Command (JPAC), traveled to Quang Nam Province to investigate the incident and interview witnesses. Teams also surveyed the crash site and found wreckage consistent with a UH-34D.

In 2000 and 2001, human remains associated with this incident were turned over to U.S. officials. In 2002, a joint team excavated the crash site and recovered additional human remains.

As a result of the remains turned over in 2000 and 2001, and of those recovered from the crash site in 2002, Ritchey's remains were identified in 2003. Some of these remains could not be individually identified, and they are included in a group representing the entire crew. Denton's remains are in this group. JPAC used forensic identification tools and circumstantial evidence in Denton's identification. The entire group is buried at Arlington National Cemetery.

**With BRAC happening quickly we are losing track of some of our customers.**

**We need anyone from recruiting and reserve commands to contact us with updated addresses. Also, if a command is not receiving the magazine directly, please contact us so we can put you on the mailing list. Also, please advise of any commands that have closed due to BRAC so we can remove them from the mailing list.**

**Please contact us at: [19native47@verizon.net](mailto:19native47@verizon.net)**

**Thank you, Janice Marie Hores, Managing Editor**

# A Corpsman's Story

HMCS(FMF) Matthew D. Lubold, USN

**H**N Lucas “Luke” Emch, a Navy corpsman assigned to the Marines, was killed on 2 March 2007 by an improvised explosive device near Ramadi, Iraq less than a month after his 21st birthday. When his death was reported, friends and acquaintances were shocked and saddened by the tragic loss of such a promising young man. The local news media covered his passing with dignity and respect. Veterans of previous wars felt the pain as they were reminded of friends and buddies they had lost. The men of his unit were especially lost without the man who had taken care of them for so long. HN Emch was eulogized and remembered. When the family was presented with Luke’s Purple Heart, the citation read “He epitomized the qualities of courage in the face of extreme danger, demonstrated complete devotion to the Marines to which he was assigned and possessed unwavering dedication to his expertise as a Hospital Corpsman.” He was posthumously promoted to the rank of third class petty officer and on 12 March 2007, he was laid to rest at Ohio Western Reserve National Cemetery in Rittman, OH.

It is difficult to put into words the effect that Luke had on the world in the short time he was with us, but to truly honor this young hero in death, you must understand who he was in life.

At first glance, Luke was a typical teenager who hated shopping, jewelry of any kind on men, and pretty much anything that could be described as “Girlie stuff,” according to his father and mother, Wesley and Julia Emch. He was

extremely fond of sleeping and was at his grumpiest when woken out of a deep sleep. His ability to make people laugh, especially when he was a passenger in a car, was legendary, according to his sister Samantha “Sammie.”

“There were times when you could barely breathe because you were laughing so hard at Luke. He just wouldn’t stop.” Luke loved to hang out with his friends; he loved to fish and be outdoors. He was an athletic, witty, intelligent, well liked teenager whose high school experience was good. Like many other American youths, he was accepted to and attended college after graduation. He was fortunate enough to have a wonderful family behind him that would allow him every opportunity to be successful. This is where the resemblance to a typical teenager ended and the true man that Luke was to become emerged.

Despite all of the opportunity, Luke saw that the country he loved was at war. According to his father, he could not live with himself if he let someone else fight for his freedom while he sat in college. “I was against him joining the Navy from the start but Luke just kept telling me that it is not fair to the guys who are in Iraq,” his father stated. “I can’t just do nothing, he told me.” His father went on to say “Luke was a self described “raging liberal” and was completely unashamed of his views. He saw people of all races, religions, or backgrounds as equal and just about the only thing he was unable to tolerate was someone bad-mouthing his country.” This sense



**Some contemplative moments preparing for the next mission.** All photos courtesy of the Emch family

of right and wrong and of duty was not just a fleeting whim that mysteriously appeared over night, but a deeply ingrained value that Luke had displayed even as a child. “Luke was the most tolerant person I ever knew,” his mother explains. “I remember Luke at the age of 7 or 8, sticking up for people who were being made fun of. He told two grown men that they were wrong. Where does a child find that kind of courage?” His sister adds “no matter what I said to him, he would always try to protect me. He would stand up for anyone who he thought couldn’t stand up for themselves.”

Luke made the decision to join the Naval Reserve so that he could continue his education but serve his country. Having completed boot camp, hospital corps school, and the training at Field Medical Service School, he was able to come home and go back to school. He kept in close contact with his friends on active duty but as he heard that they were getting ready to deploy, he felt that it would be wrong to stay at home when he was trained to save lives. “I remember the day he

showed up at my house asking if he could stay because he had just come onto active duty,” close friend HM3 Shawn Dezern said. “We stayed up all night just talking about everything. I just remember thinking that this guy is the real deal. Luke taught me what it means to be a friend and I can never thank him enough for that.”

HM3 Dezern describes a moment that truly captured what Luke meant to him. “One night, Luke and I were hanging out and I walked downstairs. He was sitting with a pair of shades on at about 2:30 am. I asked him why he was wearing shades so late to which he answered, because the sun never sets on a badass.”

Luke deployed to Iraq with 1st Marine Logistic Groups and was assigned as the company corpsman for the Explosive Ordnance Detachment. He immediately became an integral part of the team. He did everything that was expected of him and more. It is hard to imagine that a 20-year-old man could be trusted as much as Luke. He made sure every one of his Marines was okay and refused to let them go outside the wire without him. If they got hurt, he would not leave their side until he was confident that they were being well cared for. Luke would strive to make sure that every Marine he cared for would get home.

To an outside observer, this sense of duty seems so out of the ordinary and almost unbelievable but that was



Left to right: HM3 Emch, HM3 Cooper, HM3 Garcia, and HM3 Saunders, on station in Iraq.

simply who Luke was. Despite the almost continuous missions, he tried to protect his family from worry by telling them he was fine and in no real danger. The reality was that he was out there on every mission he could get on. He did what corpsmen do and he was proud of it. He was proud to wear the uniform and proud to stand next to the Marines with whom he had shared so much. He understood the consequences of his actions and knew every time he went out he was at risk. But he also understood the consequence of inaction. It is impossible to imagine the thoughts that were going through Luke’s mind in the days, hours, and minutes leading up to his death but it is safe to say that he understood that his family, his friends, and his country were worth whatever sacrifice he would be asked to make.

In the days and months following his tragic death, Wesley, Julia, and Sammie spent countless hours trying to come to terms with the enormity of their loss. They took Luke’s truck and created an airbrushed memorial to the son and brother they had lost. They tried to understand why someone with Luke’s potential would be taken from them so soon. “He was special,” Wes would say of his son. “I know that anyone who loses a son will say that but he was a rare human being who was destined for greatness. My greatest fear is that people will forget what my son and my family have done for this country.”

Luke’s sister summarized Luke’s life by saying “Luke was a man of great principle who was tolerant of everyone regardless of their background. He would always defend someone who could not defend themselves, and I know that he loved his family more than anything else in this world. He taught me to not take people I love for granted and to always try to make the people around me happy. I will miss him every day of my life.”

HM3(FMF) Lucas “Luke” Emch was the epitome of the American spirit but he was also a son, brother, grandson, friend, and shipmate. Luke may be physically gone from this earth but his presence will be felt for generations to come as long as there are corpsmen in the Navy and as long as there are Marines who need their “Doc.” Luke will be remembered and revered. There is nothing that can be said to take away or ease the pain that the Emch family must bear; however, they have requested that anyone who may have a story or who may have known Luke, feel free to contact them and share their story at [phagel@sbcglobal.net](mailto:phagel@sbcglobal.net)

HMCS(FMF) Lubold is Hospital Corps Action Officer/Planner, Bureau of Medicine and Surgery, Washington, DC.





# “From Every Direction”

Randy Hudson

*Even before Saigon fell on the last day of April 1975 ending the Vietnam War, the final stage of America’s exit—Operation Frequent Wind—had already begun. This so-called “aerial Dunkirk” was the large-scale helicopter evacuation from Saigon of American staff and selected South Vietnamese personnel and their families who had been trapped by the North Vietnamese offensive. Marine helicopters flew out to sea to land their passengers aboard carriers and amphibious assault ships lying offshore. But waves of Vietnamese military helicopters packed with refugees followed in their wake seeking any vessel that might offer a landing deck.*

*HM2 Randy Hudson joined the Navy in 1971. After hospital corps school in San Diego, he drew an assignment at Naval Hospital Portsmouth, VA, then went for preventive medicine training in Oakland, CA. He soon received orders to the carrier USS Hancock (CVA-19). “It wasn’t my choice. It just happened that way.”*

Being a corpsman, I was assigned to sick bay. My specialty training at Oakland was in preventive medicine. I was given a tiny office in sick bay aboard *Hancock*. After that I didn’t have much to do with anybody else because preventive medicine was such a unique specialty.

I arrived aboard in September 1973. *Hancock* was the Navy’s oldest carrier, and we knew this was going to be the last WESTPAC [Western Pacific] cruise. The ship was in drydock at the time with a lot of dirt and a great deal of painting going on. It was a really loud, messy place to be. In fact, we didn’t have our first shakedown cruise until 18 months later.

When we got under way in the spring of 1975, we thought we’d go to Hawaii and then the Philippines. About halfway to Hawaii, the skipper got on the IMC [loudspeaker]

and filled us in on the situation. He said we were changing course. We had no Internet back then so we believed everything the skipper said. He was the source. He told us we were going to be involved in a bigger operation and that our role would probably remain as support. We’d let the air wing off in Hawaii and take helicopters aboard.

After we left Hawaii and headed for the Philippines, we thought we’d probably just float around and not get very involved with any of the activity because of our carrier’s age. But while

in the Philippines, circumstances apparently began getting hotter. In fact, the skipper told us the situation was quite precarious as we headed back out toward Vietnam.



Refugees arrive aboard a Navy vessel. U.S. Navy photo

Nevertheless, we still didn't think we were going to take aboard any evacuees because Operation Frequent Wind initially emphasized air evacuations from the airport in Saigon. But after the enemy bombed Tan Son Nhut airport, we began conducting helicopter evacuations. The situation escalated from that point and Vietnamese began descending on the embassy. They were even plucking people off the embassy roof.

When we heard that evacuees would soon be arriving aboard *Hancock*, our senior medical officer reminded us that they would be coming from a plague-endemic area. As a safety precaution, those of the crew who had not had the plague immunization received shots. This was one of the worst shots I've ever had. We were then instructed to dust the incoming evacuees with Lindane\* using old-fashioned hand pump sprayers.

My first encounter with these refugees occurred when they came off the helicopters. We had been given some rudimentary Vietnamese lessons prior to that time period. I don't know whether we were speaking gibberish or actually speaking the language, but we said, "Yamaki," which means "Cover your eyes, and then turn around so we can spray you down." In retrospect, I wonder if any of that spraying was effective or even necessary. It was a dignity issue to me. I looked at that period of evacuation several years later and said, "What a welcome to America!"

Some of the evacuees were elderly. Others were families with children. Some refugees were our age. There were more children than I expected to see. Adults with young children wanted to get out more than anybody else to protect their kids.

We called them "refugees" but they weren't in wretched condition. They

were from Saigon, a big city, and were mostly middle class. None of them were in rags, and they seemed to be in pretty good condition.

I suspect many were very frightened having just left their country—their homes—and having to get on a helicopter. I don't know if anyone had an outright panic attack but there was definitely an air of excitement and urgency. Crewmembers on the *Hancock* shouted, "Come on! Get out of the helicopter! Get on down here!" Everything happened so fast!

I saw a lot of helicopters land. In fact, it's amazing that we had only

***I understood many of the helicopters were ready to run out of fuel so it was getting to be a desperate situation. So many choppers were trying to land that our crew began pushing them over the side to make room for more.***

one casualty and that was a Marine helicopter. To this day, I'm still very surprised we didn't have any mid-air collisions because they were coming from every direction. It was complete chaos. Those helicopters were coming so frequently, the sky was dark from jet exhaust. Most were Hueys but there were also a few Chinooks flown by Marine crews. They carried large numbers of refugees.

Once all the evacuees were on-board, we began steaming toward the Philippines. By this time the whole hangar bay was crowded with people. Some of the crew had the opportunity to visit with them. Most didn't speak very good English but I was able to get some Vietnamese money—a

1,000-dong note and some coins—for souvenirs.

Everybody was all spread out sleeping on the hangar deck. Some had their own blankets. Everyone brought a bag containing their most prized possessions.

To accommodate their personal needs, wooden troughs had been set up rather quickly on the port and starboard sides. Seawater moved along the troughs and then emptied near the fantail. I asked, "What in the world is that thing for?" Answer: the toilet facility. The skipper didn't want all those refugees wandering around the *Hancock* trying to find a toilet.

But the refugees didn't use the troughs for that purpose. They began washing their clothes in them. I don't know whether or not they were also using them for toilets. They may have been washing their clothes up forward and then toileting aft.

Feeding all those refugees took a long time as they walked through the enlisted mess deck. I don't know whether they ate down there or brought their food up to the hangar bay, but it took hours to get through the chow line.

When we got to Subic, the refugees were off-loaded. Many went to Guam. Many years after I got out of the Navy, I was director of a gastroenterology lab at Texas Tech University in Lubbock. One of our gastroenterology fellows was Asian. When I asked him where he was from, he said he was originally from Vietnam.

"When Saigon fell in 1975," he told me, "we were transported by helicopter to an aircraft carrier, the USS *Hancock*."

I never got to talk to that fellow again, but it was an interesting coincidence and a great story. ✍

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Randy Hudson is currently Director of Education at Southwest Regional Medical Complex in Lubbock, TX.

# BUILDING A SEA-BASED MEDICAL SUPPORT SYSTEM

## PART V: The Case for Joint Medical Command and Control

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

### AN ERA OF UNCERTAIN ACCESS

**E**merging conditions of uncertain and contested access throughout the world may impede the ready availability of secure land bases for future U.S. military operations. The U.S. has consequently initiated a shift away from a garrison posture towards one which emphasizes the forward deployment of combat forces from bases located upon either limited remaining American sovereign territories such as Guam, or upon the open seas. The latter option would appear to be a very flexible environment for supporting power-projection operations and staging joint expeditionary forces. In this context, the United States will need mobile seaborne facilities to serve as bases for facilitating activities such as the seizure of access ashore, as well as for disaster relief and humanitarian assistance operations.

The concept of sea-basing requires a series of complex platforms, connectors, and logistics technologies driven by a common set of standards, requirements, timeframes, and priorities. Various ship, airlift, and sealift connector components of the sea base will need to interface, and the capabilities of some of these components must inevitably be interdependent. In addition, joint operations from a sea base will require robust logistics technolo-

gies as well as command and control. Systems for supporting casualties accrued during distributed operations based at sea are no exception.

The ability of joint forces to respond with appropriate capabilities is inherent in any establishment of basing at sea, or global fleet stationing of resources. The ultimate goal is to facilitate the capability, when needed, for aggregating, disaggregating, and re-aggregating forces at sea and ashore as threats dictate. Since differing directions are being explored by the services for the conduct of expeditionary operations launched from bases at sea, premature development of future medical support systems to meet individual service needs, rather than joint requirements, may result in initiatives that not only duplicate one another but may be neither interoperable nor compatible.<sup>(1)</sup>

### JOINT EXPEDITIONARY OPERATIONS

During the period leading up to and including World War II, joint operations involving the Navy, Marine Corps, and Army were guided by the principle of “mutual cooperation.” In actual practice, this meant that the services collaborated primarily when it was in their own best interests to do so. During the Cold War, despite repeated attempts to achieve unified action, the services jealously guarded

and maintained their own independence. This did not translate well into collaborative and effective operational performance. The mixed or unhappy outcomes of the Korean and Vietnam Wars, fumbled operations such as the Mayaguez Incident, and the Iranian Hostage Rescue mission, as well as the glaring joint planning and execution failures evident during interventions in Grenada and Beirut, all fed the perception that improved battlefield results would never occur unless the power and the independence of the individual services were re-directed toward unified action.

Within the narrow span of 16 years the United States fought two major wars with Iraq, conducted armed interventions in Panama, Somalia, Bosnia, Kosovo, and Afghanistan, and committed all branches of the armed forces in a number and variety of places and circumstances. During this period of high “operational tempo,” the term “expeditionary” gradually infiltrated the lexicon of all services. The shift to an expeditionary posture has required changes of varying degrees in the organizational structures of all services. Although the Marine Corps was the original force to be maintained, organized, and equipped for rapid movement and insertion into combat with little access to local bases or infrastructure, the uniqueness

of that mission must now be shared. These changes will allow the services to better support frequent rotational deployments, overseas expeditions, and surge power projection operations emanating from the continental United States.

### **DIFFERING STRATEGIES**

When U.S. combatant commands weigh future options in a setting of conflict potentially involving the maritime theater or its environs, they must still overcome significant organizational challenges. (Parenthetically, not only the individual uniformed services but other government agencies have individual stakes in maritime issues as well, bringing their own brand of institutionalized biases with them.) Therefore, in order to establish common and stable standards for building a truly joint and interoperable support network in the sea-based setting, including medical support, a spirit of cooperation and shared values must ultimately be facilitated among all the sister services and agencies, notwithstanding allied foreign military services. (An equivalent understanding of how other nations' naval forces "conduct business" on the seas is also imperative, to facilitate combined operations utilizing procedures that are well understood by all participants.) In essence, to ensure that all participants can effectively integrate their contributions, new joint and combined maritime strategies for facilitating global security must ultimately require an assurance of interoperability among domestic and foreign sea services.

On 17 October 2007, the three U.S. sea services, Navy, Marine Corps, and Coast Guard, unveiled a new joint maritime strategy, reflecting an effort on their part to produce a common strategic vision. The new strategy placed an emphasis upon cooperation and sharing in the pursuit of global security. It argued that the shared task of the sea services must be to exercise

their mastery of the seas through the effective execution of six missions: forward presence, conflict deterrence, sea control, power projection, maritime security, and humanitarian assistance. An invitation was extended to their sister services and overseas counterparts as well, whose assistance is crucial in policing the world's oceans, coastlines, and inland waterways. In essence, the proposed strategy implied that in an era of sustained, high tempo expeditionary operations and uncertain forward base access, exploiting the littoral seas as a base of joint operations in support of U.S. campaigns and objectives must be a key and enduring requirement.

### **EXPEDITIONARY MANEUVER**

Unfortunately, despite passage of the Goldwater – Nichols Act in 1986, aspirations of unity are still not easily attained, due in part to the separate and unique role that each service and nation has traditionally maintained during war. Differing perspectives still remain concerning use of the sea as either a wholly sustaining base for operations (the naval view), or alternatively (the joint maritime view) as primarily a transitory platform to facilitate the initiation of joint combat operations, with selective logistic offload from accompanying ships until a lodgment can be safely established ashore with both surface and air "bridges" established for follow-on forces.(2)

In essence, proponents of the "naval view" of sea-basing hypothesize the almost exclusive use of Navy/Sea Service forces to replace land bases. The "joint maritime strategists," however, envision sea-basing as mainly a portion of an overall joint maritime strategy in which the fleet and the other services are one weapon, with coordinated action to realize the full power of both. This latter maritime "sea as a base" concept more broadly defines a base at sea as an area or facility from which a joint or combined military force pri-

marily initiates its offensive operations. Its advocates propose using the sea primarily as a transient base of joint operations to overcome a temporary lack of land bases.

Classic expeditionary maneuver operations involve three basic steps: the deployment of combat units, their employment, and their sustainment. Traditional forces designed for "assured access" operations maintain the deployment and employment steps as separate and distinct, causing units to be broken up and deployed as separate packets of personnel, equipment and supplies, followed by reassembly and reconstitution for employment in a forward theater. Currently, personnel who would operate the equipment carried by both the Marines' legacy 16 ship Maritime Prepositioning Fleet, or aboard the 10 LMSR ships of the Army's Prepositioned Stock -3 Force, must be flown to a nearby airfield to "marry up" with the equipment and prepare for combat in a procedure known as "reception, staging, onward movement and integration" (RSOI). This process may take a week or longer, implying that forces are not ready to fight when initially delivered to a distant theater. Only after military units are reassembled, are they prepared. By contrast, a force designed for truly "uncertain access," lacking suitable sea or airports of debarkation—a more likely requirement in the current world situation—requires deployment and employment as one seamless step, ensuring that the units are transported and inserted in "ready to fight" condition. The units must be capable of conducting long range operational maneuver over and from the sea, transitioning from deployment to direct combat operations with little pause.

### **THE NAVY'S CHANGING PHILOSOPHY: THE MPF(FUTURE)**

The amphibious operations of the past were focused upon assaults over the shore and into seaports to establish

footholds or lodgments ashore, thus permitting the build-up of sufficient combat power to conduct operations against inland objectives. Forcible entry forces were placed into battle to capture and render useful any in-theater seaports and airports of debarkation. Indeed, prior to and during World War II, the United States built the Global Expeditionary Movement and Maneuver System to move large numbers of forces to the point of attack; forcing a penetration into hostile territory; creating an operational lodgment ashore; steadily reinforcing the attacking units; sustaining their attacks beyond an initial lodgment; and then moving or repositioning forces for other attacks.

In the current climate of futuristic Navy planning, traditional means for amphibious forcible entry have been adjudged as ill-suited for these emerging roles. Notional operations for a futuristic Navy conceived sea base focus upon direct assault of inland objectives by a Marine Expeditionary Brigade (with no operational pause, or "RSOI"), followed by continued sustainment from the sea base by selective replenishment of forces ashore. Within the Navy concept, it is further advocated that future forcible entry operations should be conducted primarily by vertical (aerial) insertion of forces emanating from the sea base rather than reliance upon traditional surface maneuver.

Since contemporary Navy amphibious task forces based within the continental United States could not be formed and surge moved to a distant theater in much less than 30 days, a new concept has evolved for conducting forcible entry operations more rapidly. Leadership has contended that the only possible means for achieving these newly accelerated timeline criteria for forcible entry operations is to exploit the forward deployed MPF(F) as the primary means for forcible entry and sustainment of forces. This

has initiated movement toward use of the "future" maritime pre-positioning force ships in projected forcible entry roles, rather than surging traditional amphibious assault ships.

The Navy's new concept for MPF(F) operations implies that those future ships will be multi-mission vessels, capable of both afloat prepositioning as well as conducting sea-based operations in support of amphibious assault. The result: in lieu of augmenting traditional amphibious landing ships to perform an assault/follow-on type mission, the sea base itself and its component vessels, many of which have hulls constructed to commercial standards only, and manned by civilian mariners, would in effect become the leading edge of the forcible entry operation. This differs sharply from current practices which would utilize existing legacy MPF maritime prepositioning ships to primarily support, and not replace, amphibious assault ships.

These proposals have been reflected in a gradual de-emphasis within Navy shipbuilding plans for amphibious assault ships in general, and surface amphibious assault capabilities in particular. As late as 2005, the Navy planned to cut the total number of amphibious assault ships in its battle fleet from 36 to between 17 and 24 ships. More recently, the Navy has readjusted its proposal to a total of 31 amphibious ships as well as the additional squadron of 14 Maritime Prepositioned Ships (future) ships. Moreover, during the planned replacements for five "big deck" amphibious assault ships, the LHA(R)s have "lost" their well decks in favor of increased aviation capacity.

#### **THE BOTTOM LINE**

A primary goal of the "base at sea" concept is to improve and augment "access insensitive" capabilities, implying forces that can be operated with little or no reliance on bases or other logistics infrastructure on the ground in the immediate area, even if

confronted by a determined adversary. Ultimately, there is a need for a fleet of selective offload cargo ships operating independent of port facilities, optimized for supporting joint forces operating ashore until a theater logistics infrastructure can be established. The vessels would also support operations ashore in cases where the establishment of a large logistics footprint may be inappropriate, or during humanitarian and disaster relief undertakings when the infrastructure ashore has been destroyed.

The mechanism for accomplishing this is the plan to first deploy these "bases at sea," and to concurrently transport, employ, and sustain ground forces from the ships comprising the base.

#### **A MEDICAL COMMAND ELEMENT**

Given the variability among individual service perspectives on joint/combined sea-based operations, a unified and free standing medical command element is proposed for sea-based operations, removed from the traditional logistics staff umbrella. The medical command and control element should be specifically responsible for operational control over joint medical functions, regardless of the prevailing operational configuration.

Such responsibility would be best vested in a single entity or individual appropriately placed within the command structure, with both adequate staff to discharge these responsibilities and clearly delineated authority and accountability. Likewise, there must be a clear and functional chain of command within this entity that can develop as well as execute joint medical plans involving the sea base. This "medical command element" would promulgate local doctrine sufficient to guide not only joint medical planning but also that of each service in the joint task force. Consequently, authority must be delegated by the chain of command to the command medical

element to ensure that these principles are incorporated into operational medical planning at every echelon and that the plans developed by service components are both coherent and compatible.

The medical command element would also:

Ensure that the sea-base medical system can integrate with the joint strategic patient evacuation system in wartime as well as during contingencies.

Ensure that responsibility for control of the tactical and strategic components of the medical evacuation system lies within the same chain of command and that clear guidelines regarding aircraft destinations and patient distributions, as well as priorities for medical evacuation, are promulgated.

Ensure that the system of medical communications at the joint level, as well as within the various components of the sea base, are sufficient to support wartime medical operations, are simple and direct, and will work reliably during times of crisis.

Determine whether the sea base can accept biological, chemical, or radiological warfare casualties.

Ensure that adequate mechanisms exist in the medical planning system for assessing the capabilities of friendly nations to provide hospitalization and evacuation support in the event of mass casualties, and also for arranging that support via adequate means of swift communication channels.

### **WILL IT WORK?**

Military innovation and improvements are fostered by developing new concepts and organizational ideas, testing them, transferring them into operational reality, and then employing them. The concept of a deployable joint medical command element within sea-based operations is surely worthy of similar consideration. It took two decades of experimentation,

war gaming, and analysis for the Navy to fully integrate aircraft carriers into fleet operations. The sea-basing concept in general, and its casualty care component, appear to be at least as complicated. Given the existing controversies regarding the constitution and operational orientation of joint sea-based forcible entry forces of the future, the workability of this aspect of personnel support could be very much open to question, especially given the lack of operational experimentation to back it up.

In the absence of a current overarching joint experimentation campaign plan for exploring military doctrine, operational concepts, and organizational arrangements, many sea-basing investigations—including war gaming, command post exercises, operations analysis, workshops, technological development, modeling and simulation, platform prototyping, and live demonstrations—have taken place across the services, combatant commands, and other defense entities, without the ability to evaluate solutions or to coordinate efforts.

Medical considerations must be viewed likewise, since there have been insufficient modeling and simulation tools available to provide valid data on casualty care requirements within a framework of joint seabasing. These deficiencies will clearly impact upon medical doctrine and training as well as any concrete solutions that may be proposed for dealing with the combat wounded.

Ultimately, the Navy must coordinate with other services on establishing stable standards for building a truly joint and interoperable medical support network. To establish medical support for future networked and distributed sea-based operations, a familiarity is also required with the differing trends in war fighting being proposed by the various combat arms communities. Such differences in perspective may bias the prevail-

ing mission concept being employed, and ultimately complicate the mechanisms for delivery of medical support. Significant adaptability on the part of health care services will be required, if abetted by an appreciation for the differing sea-basing strategies being employed.

The medical people who are now practicing “good medicine in bad places” are far better prepared than ever before. Now, they need to be given a command structure and proper resources to do their job even better.

### **Notes:**

1. “Joint Seabasing Would Benefit from a Comprehensive Management Approach and Rigorous Experimentation before Services Spend Billions on New Capabilities.” Government Accountability Office report GAO-07-211, January 2007.

2. For excellent resources dealing with the history of Sea-basing and the military requirements for implementation, see:

Work, R., and Krepinevich, A., “A New Global Defense Posture For The Second Transoceanic Era.” Center for Strategic and Budgetary Assessments, Washington, DC, 20 April 2007

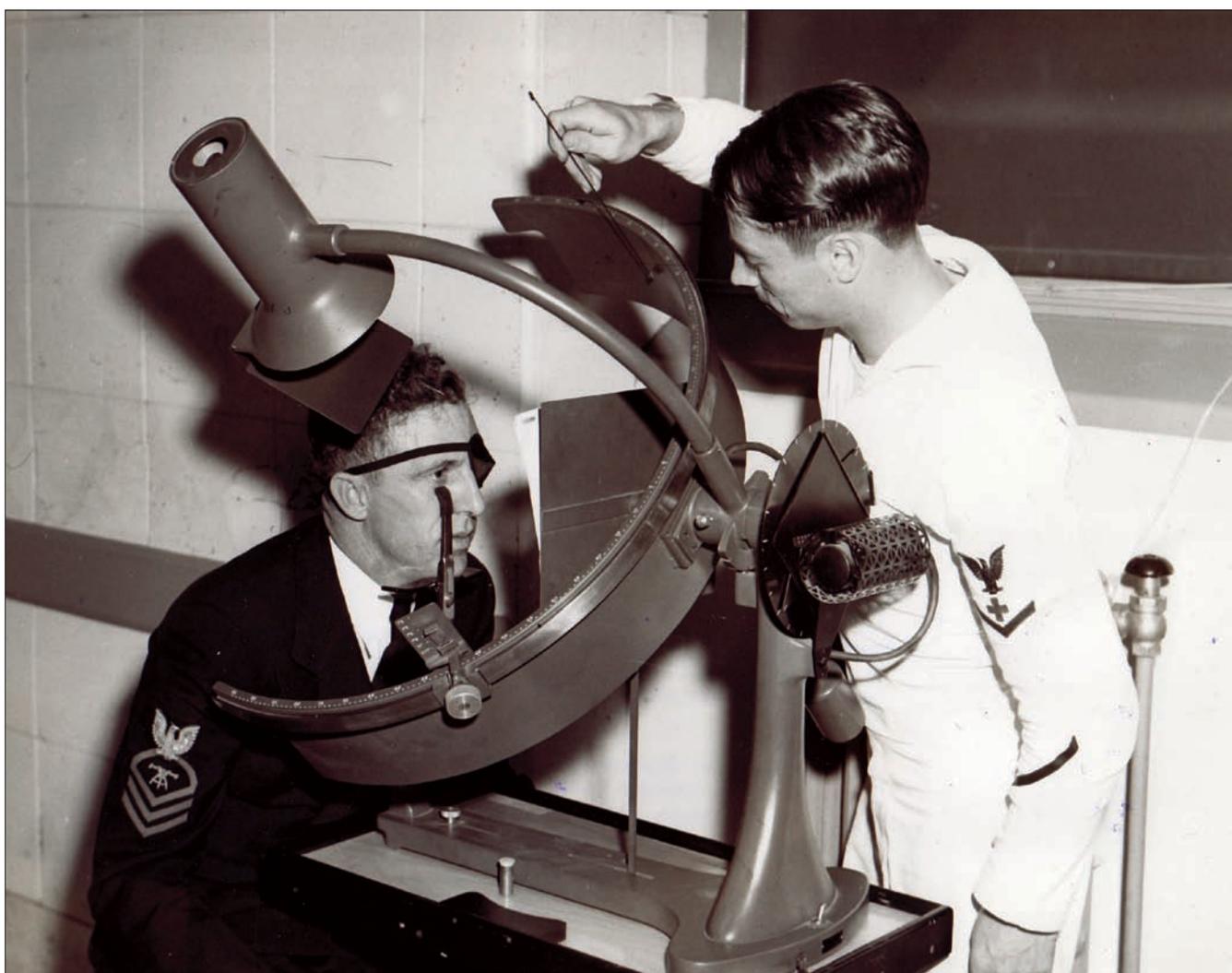
Work, R., “Sea Basing: All Ahead Slow,” Center for Strategic and Budgetary Assessments 1 March 2006

[Both works by COL Robert Work, USMC (Ret.) can be viewed at: [www.csbaonline.org](http://www.csbaonline.org)]

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# Navy Medicine 1948



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Hospital corpsman uses a perimeter to determine a patient's range of vision.

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