



THE GROG

A Journal of Navy Medical History and Culture

Navy Medicine in the War of 1812

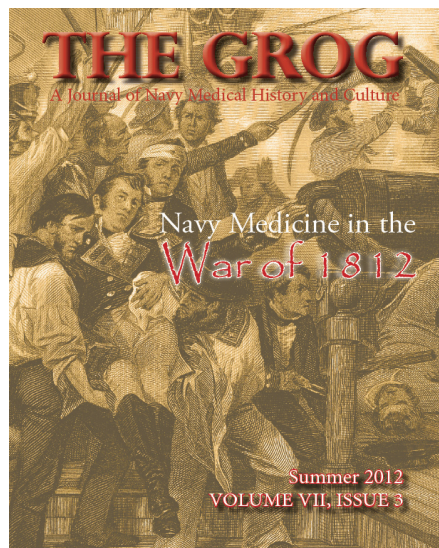
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"Don't Give Up the Ship!"

Engraving by H.B. Hall after the original painting by Alonzo Chappell

Courtesy of Navy Art Museum

OFFICE OF MEDICAL HISTORY
COMMUNICATIONS DIRECTORATE
BUREAU OF MEDICINE & SURGERY
2300 E STREET, NW
WASHINGTON, DC 20372-5300

Editor and Historian:

Mr. André B. Sobocinski

Archivist:

Mr. Mike Rhode

Design Consultant:

Marcia L. Sobocinski

Oral History Editor:

COL Dick Ginn, MSC, USA (Ret.)

INTRODUCTION

This summer marks the 200th anniversary of the start of the War of 1812. For the United States, the legacy of the conflict is a mixed-bag. The war gave us the "Star-Spangled Banner," "Old Ironsides," and a stage from which our Navy (with few exceptions) launched a reputation of renown. But the "glories" of the war were offset by many less than stellar lowlights including the failed invasions of Canada, the destruction of the White House and Capitol Building, and the nation falling into bankruptcy in 1814. When the Treaty of Ghent was signed on Christmas Day 1814, very little, if anything, was gained by either Great Britain or the United States. For the then 36-year old country, we could attribute the war as an exercise in "sowing one's [nation's] oats."

Like the United States, the U.S. Navy Medical Department was still in a developmental stage in 1812. First, Navy Medicine was quite small, consisting of 52 physicians (surgeons and surgeon's mates) in 1812 and only 91 by the end the war. Second, the profession of medicine had not yet progressed past its "heroic age" when the concept of "patient care" was relative and the tried and true "cures" were anything but.

In this edition of THE GROG we take a look back at Navy Medicine in the War of 1812, "Under Lantern Light." We follow this with John Matchim's original article, "Making Jack-Tar Healthy" which examines major trends in nineteenth century health and medicine and how they triggered significant reforms in the Royal Navy.

In "CAPT Robert Koffman and the Genesis of the Mobile Care Team," COL Ginn explores one of Navy Medicine's valuable contributions to combat operations in Afghanistan.

Finally, in this centennial year of the Dental Corps we look back at some of the pioneering dentists.

As always we hope you enjoy this humble ocean voyage on the seas of Navy medicine's past.



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THE GROG is a free quarterly publication of the Communications Directorate dedicated to the promotion and preservation of the history and culture of the Navy Medical Department. Articles and information published in THE GROG are historical and are not meant to reflect the present-day policy of the Navy Medical Department, U.S. Navy, and/or the Department of Defense.



USS *Constitution* versus HMS *Java*, 29 December 1812

by Anton Otto Fischer

Oil on canvas, 1960

Courtesy of Navy Art Museum



Under the Lantern Light: Navy Medicine in the War of 1812

1 June 1813. 25 miles off the coast of Boston, MA. Surgeon Richard C. Edgar¹ and Surgeon's Mate John Dix² had more than their share of patients to attend to in the cramped, dimly-lit cockpit hidden in the depths of USS Chesapeake. Out of the ship's 379 crewmembers, 85 were wounded and 61 were killed outright or died soon after the 15-minute melee with HMS Shannon. In what may be termed as a "master class" of early nineteenth century war medicine, Drs. Edgar and Dix dressed wounds, applied tourniquets, sawed off limbs and cauterized stumps with "hot pitch."³ Their most notable patient that day, CAPT James Lawrence, suffered from musket wounds to the right leg and intestines. His leg could be amputated, and he could be given laudanum for his pain, but the intestinal wound was fatal. In his anguished state, Lawrence is said to have cried out to his doctors to "keep the guns going" and, repeatedly, "Don't give up the ship!" Lawrence would linger another three days before succumbing to his injuries. His final words, first spoken to Drs. Edgar and Dix, would survive to this day as a motto of the U.S. Navy.

In this bicentennial of the War of 1812, we look back to see the U.S. Navy Medical Department in its true infancy and a time when the fields of medicine and surgery had not yet caught up with the well-meaning intentions of the medical providers. Even without warfare, saving lives in the early nineteenth century was goal few could meet. When war began on 18 June 1812, medicine was still in its "heroic age"—there were no antibi-

otics, no anesthesia, no knowledge of germ theory, no professional nurses, no triage, no treatment of mental illness, very little clinical training available at American medical schools, and dental care existed only in a very crude form. Navy Surgeons and Surgeon's Mates practiced their "healing craft" with ample supply of antiquated knowledge and almost sheer will. Blood-letting, blistering, and purging were still in common practice. Shipboard

1. Dr. Richard Clarke Edgar of Maryland was commissioned in the Navy in 1809 at the age of nineteen. He died of yellow fever at the Navy's first base in Florida (Thompson's Island, later known as Key West) in June 1823.

2. Dr. John Dix of Massachusetts was commissioned as a Surgeon's Mate in the Navy in 1813. Dr. Dix died of yellow fever off the coast of Africa in April 1823.

3. Hot pitch or asphalt was commonly applied to wounds and stumps to control haemorrhaging.

medical kits⁴ contained the usual assortment of anodynes, antiarthritics, astringents, cathartics, emetics, diaphoretics, diuretics, rubefacients, stimulants and tonics—some of which was perfectly equipped to induce a host of iatrogenic⁵ disorders. Calomel (mercury chloride) and jalap (a poisonous root) were commonly used to stimulate the intestinal tract and rid intestinal irritation. Peruvian bark (later known as quinine) was used in the treatment of malaria and other malignant fevers. Potassium acetate was used to increase secretion and flow of urine. Opium and laudanum were used to relieve pain and induce sleep. Teas and tonics were commonly used to settle digestive complaints.

During the war, Navy medical personnel (numbering 26 surgeon's and 26 surgeon's mates in 1812 and 44 surgeons and 47 surgeon's mates by the end of the war) served aboard the full spectrum of warship—frigates, sloops-of-war, schooners, brigs, and gunboats. Back on shore, Navy medical personnel also served ashore at Marine hospitals (equivalent to Public Health Service hospitals), Navy medical hospitals, and Navy and Marine Corps Rendezvous (equivalent to recruiting stations). Permanent Navy hospitals were still over a decade away; all Navy hospitals at the time were makeshift and temporary facilities located on or near Navy yards in



Surgical kit used by Surgeon Archimides Smith, USN, aboard USS *Lawrence* and USS *Niagara* during the Battle of Lake Erie, 10 September 1813. (1) bone saw, (2) artery clamp or hemostat, (3) forceps clamp, (4) bone scraper, (5) surgical/amputation knives, (6) tenaculum, (7) scalpels.

Courtesy of Navy History & Heritage Command

Brooklyn, NY, Charleston, SC, Erie, PA, New Castle, DE, New Orleans, LA, Newport, RI, Norfolk, VA, Philadelphia, PA, Portland, ME,

Sacket's Harbor, NY, Savannah, St. Mary's and Sunbury, GA, Washington, DC, and Wilmington, NC.

For our Navy physicians in the

4. Common medicines in the War of 1812: anodynes (e.g., Laudanum, opium), antiarthritics (e.g., Epsom Salts, Peruvian Bark), astringents (Goulard's Extract, alum), cathartics (e.g., Glauber's Salts, Plummer's Pills, ipecac), emetics (e.g., Tartar emetic), diaphoretics (e.g., Dover's Powder), diuretics (e.g., Potassium acetate), rubefacients (e.g., oil of Turpentine).

5. iatrogenic or "doctor induced disorders." From the Greek *iatros* ("doctor" or "treatment") and *gainein* ("to produce")

War of 1812, operational medicine meant repairing damage caused by cannon balls, grape shot and musket fire as well as attending to those suffering from the shipboard occupational injuries and diseases of the day. The medical trade called for amputation, application of tourniquets, bandaging removing splinters, and cleaning wounds (i.e., removing musket balls, metal and wood from open wounds). Location of the wound was key—there was nothing a Navy surgeon could do for injuries to the abdomen and thoracic cavity other than administer opium for pain relief. Most surgeries were performed under lantern light in ship cockpits (or junior officer's quarters) located in the depths of the orlop deck. Ambulatory patients were allowed to return to shipboard duties or given menial

tasks. Those needing more time to recuperate rested in their hammocks located in the berth decks (directly below the gun deck!) as the ever-malodorous smells of dry rot, dead rat and bilge water wafted through the compartments. Patients requiring continued medical care were kept shipboard until they could be transferred to the nearest Marine or Navy hospital.

From the perspective of 21st century military medical care it is easy to look back and marvel how anyone—patient and medical practitioner alike—survived disease and injury in the War of 1812. If the ailment did not kill you the “heroic” measures of doctors possibly could. Navy Medicine has come a long way in 200 years. Injured sailors and Marines who would have been deemed hopeless causes are

now being saved on a regular basis through the advances in wound management and internal hemorrhage control. The frontline medical care and rapid evacuation to higher echelon medical facilities have made every bit the difference between life and death in the wars in Afghanistan and Iraq. Loss of limb in combat is nothing new; but with the advances in prosthetic research and design, artificial limbs have become less so for amputees. And like never before, military members with traumatic brain injury and post-traumatic stress disorder are receiving the medical attention they deserve. If present-day science had been available to the early Navy physicians CAPT Lawrence may have survived martyrdom and his impassioned plea would have been forgotten long ago. ~ABS

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WOUNDED SAILORS LISTENING TO MUSIC ONBOARD SHIP

Oil on Canvas, 1918

By Oswald Moser

Onboard a ship seven men are lying down in temporary beds on the deck, some in partial military uniform wearing caps and jackets. Around the men stand and sit other figures; doctors, sailors (some injured) and orderlies, all listening to a band in the foreground. The band has a piano, two violins, and two men play the flute. The painting has a large tear in the top left, and a smaller one to the right.

All images courtesy of the Wellcome Library, London



Making Jack-Tar¹ Healthy:

Medicine and Hygiene in the Royal Navy

By John Matchim

In the 1840s, the Royal Navy was facing a manning problem. The reputation of naval service was poor and though Continuous Service² introduced fixed terms of service, conditions at sea remained severe. Meager pay, inadequate clothing, poor diet, debilitating working conditions, and the notorious legacy of the press gangs discouraged potential recruits. The Navy would have to do better, but in the rough-and-ready age of sail life was necessarily tough; after all, Napoleon was not defeated by sympathetic reformers.

Like many other aspects of British life in the nineteenth century, however, industrialization would force the pace of change. While the sailors of the Royal Navy were most visibly affected by the material changes of new ship technology, Britain's emerging industrial and scientific society would engender many other changes as well. Scientific medicine, Victorian concepts of hygiene and morality, health

problems particular to a rapidly urbanizing population, and industrial discipline of labor would also have implications for life in the lower-decks of the British fleet.

In this article, I will outline some of the major trends in nineteenth century health and medicine and demonstrate how they triggered similar changes in the Royal Navy. In particular, I will discuss the introduction of uniforms, the reduction of the rum ration, and the rise to professional status of the naval surgeon. While this transformation would lift the health of the navy to impressive new heights it would also redefine traditional seamanship.

PART I: HEALTH AND THE NATION

The labor requirements of industrial production were unlike anything that came before. Men, women and children had to be disciplined into accepting long hours of servile and dangerous labor under heavily mechanized conditions, and for the first time "workers" emerged

1. Jack-Tar is a common nickname for Royal Navy sailors. From "Jack," a common name for a sailor plus "tar," used to waterproof sails as well as the seams between planks on wooden ships (1781). Sailors also used tar for clothing, grooming: their coats and hats, were made of the waterproof fabric called tarpaulin; seamen commonly pleated their long hair into a pigtail and smeared it with high grade tar to prevent it getting caught in the ship's equipment, a practice that continued until the early 20th century.

2. By Royal Navy standards "Continuous Service" was considered military service of 10 years or more.

as a distinct social-economic group to be housed, fed and tied into the industrial system. The health and well-being of workers was initially of little concern to industrial owners; what mattered most was having access to a large surplus labor pool that was always available to fill the new or expanding factories. How those workers survived during periods of recession mattered not at all. However, as growing numbers of people emigrated from the countryside into overcrowding towns and cities, waves of cholera, tuberculosis and typhoid swept the urban slums and wiped out productive labor. Health reforms were clearly required if urban and industrial disruption was to be minimized.

To address the decimating spread of infectious diseases, Parliament appointed a committee to investigate urban conditions. Chaired by the lawyer Edmund Chadwick, the committee concluded that urban neighborhoods would have to be provided with wider streets and better sanitation, drainage and ventilation. The report identified environment and population groups as the source of health problems, rather than the individual.³ This distinction is important: the primary objectives of health and sanitary reforms were hygienic, and would become increasingly associated with preserving and improving the productive capacity of British labor in general,

rather than any providential effort to improve the living conditions of poor and vulnerable private citizens. Chadwick's report sparked a great hygienic movement—more of a conviction—that is now identified as the Great Sanitary Awakening (GSA).

Hygienists further concluded that the filthy conditions of working neighborhoods not only engendered infectious disease but also induced a culture of laziness, dependency, and moral decline that could only inflict long term damage on the nation. The conviction that physical and mental health were synonymous naturally emerged as a central tenant of the Victorian temperance movement, perhaps the most visible outgrowth of the GSA. Convinced that alcohol and prostitution threatened the health and integrity of society, state, and empire, temperance campaigners enjoyed a sympathetic following among Britain's ruling and middle classes. Because the temperance societies were heavily supported by evangelical Christians and those in positions of authority, it is easy to dismiss the movement as a moralizing crusade imposed from above. However, the grinding realities of working-class life in Victorian Britain meant that alcoholism a very real problem, and families and communities did suffer for it. There was more popular support for temperance than we can ap-

preciate today.

Victorian Britain's code of hygiene and morality was not the only facet of the industrial revolution's Great Sanitary Awakening. The accumulation of wealth and technical expertise that accompanied the Industrial Revolution launched "scientific" medicine into its own orbit, with British universities graduating 8,000 medical practitioners between 1800 and 1850, many of whom would join Britain's rapidly expanding hospital system.⁴ Medical science promised that knowledge of the human body could be matched by actual treatment of the body, and together with recurring outbreaks of infectious diseases, Victorians became conditioned to thinking about the health of their bodies.

While even the concept of universal access to medical care remained many decades away, by the close of the Victorian period certain minimum standards of health and morality were considered essential to economic productivity and national security. Governments and industrialists, with the help of university educated physicians, actively monitored population bodies for health risks, while hygienists sought to shape the lifestyle and values of working-class people. Workers, and sailors as well- were expected to be strong in mind as well as body, independent, and committed equally to family, work and empire.

3. House of Commons Parliamentary Papers [82]. Report to Her Majesty's Principle Secretary of State for the Home Department, from the Poor Law Commissioners, on an enquiry into the Sanitary condition of the labouring population of Great Britain. London: W. Clowes and Sons, 1842.

4. Haley, Bruce. *The Healthy Body and Victorian Culture*. Cambridge, Mass.: Harvard University Press, 1978. 5.

PART II: HEALTH AND THE NAVY

The sailing man-of-war was a sophisticated and superbly engineered war machine that required considerable expertise and infrastructure to build and maintain. However, for hundreds of years there were only incremental advances in shipbuilding technology and it was not until the nineteenth century that navies were confronted with radical change. Nevertheless, British admirals were highly responsive to industrial engineering and by the end of the century the Royal Navy had successfully managed the transition from wood and canvas sail to coal and compound steel. But the material transformation is only part of the story; as we have seen, there were many other social and scientific changes borne of industrial society, and they would reshape the British fleet in equally significant—if less tangible ways.

Like the laborers of the new industrial working-class the sailors of the Royal Navy would experience a transformation in function and identity that would change them quite as dramatically as the ships they "sailed." Industrial discipline and specialization would turn sailing from an ancient craft into a modern "skill," and reforms in health and medicine would be an integral part of that process. The introduction of Continuous Service marked a distinct break with the age of sail, even



Wounded sailors on HMS Warrior lying on stretchers, 1919

before new ship technology had finally ended the long reign of sail. No more would the navy force men into the service against their will; the fleet would be crewed by volunteers serving ten year contracts, with a small pension for those who completed twenty. Some members of the Admiralty staunchly opposed the new system. Admiral Sir Byron Martin, "a good old sea dog," argued that while "Demagogues treat it as a trespass on the liberties of the people" they did not appreciate that it has its "justification in the prompt protection that it enables the fleet to give our country."⁵ However, "in the age of Dickens and liberal humanitarian reform" the British public could not sympathize with the opinions of old admirals. Impressment was finished.⁶

Continuous Service did away with multinational crews, imposed age brackets, drew recruits from all over the United Kingdom (and not just the seaport towns), introduced medical examinations, standardized uniforms and kits, and provided a framework for a more modern system of discipline and punishment that finally abolished the rule of the lash. In many respects, Continuous Service incorporated many of the features then being applied to Britain's rapidly expanding industrial work force, in other ways it provided naval labor with working conditions far better and more progressive than those found in the factories ashore.

Around the mid-nineteenth century the Medical Branch of the Royal Navy began pressing the Admiralty to introduce standardized uniforms

5. Quoted from J.F. Somerville, "The Lower Deck Past and Present, Part I," *Royal United Services Institute Journal* 81 (February/November 1936), 116.

6. Arthur Herman, *To Rule the Waves: How the British Navy Shaped the Modern World* (New York; London: Harper Perennial, 2005), 453.

for all lower-deck ratings, a suggestion that was adopted in 1856. The prevailing style of dress during the Napoleonic Wars consisted of eclectic combinations of straw hats, blue jackets, linen pants, neckerchiefs and pig tails. The physicians argued that uniforms would minimize louse-borne diseases such as typhus while also improving personal hygiene, but the navy found further advantages in uniform clothing. Cleanliness could be used as an instrument of discipline, particularly useful in assimilating unruly and unclean merchant sailors. "Seafaring men who have not been brought up in a man-of-war," one manning commissioner declared, "are very slovenly and dirty in their habits."⁷ While sailors complained that the new uniforms were uncomfortable and exposed they likely resented the loss of one of their few outlets of personal expression even more.

The Royal Navy also sought to reduce the daily ration of rum, which it believed was unsuited to a modern mechanized fleet and a hindrance to discipline. Some kind of alcoholic ration had long been available to the sailors of the Royal Navy, liquor being "the very cement that keeps the mariner's body and soul together."⁸ A strong serving of rum, or grog,

was issued to relieve the hardships that were the everyday diet of the naval sailor. While the ration was halved in 1825, the substitution of the imperial for the wine measure actually added 1/5 to the ration.

In 1851, a committee was appointed to consider a more meaningful reduction, and by this time the temperance movement had emerged as a social force in Britain. Campaigners were horrified at Queen Victoria's "apparent fondness for naval grog" when she sampled it at a naval review in 1842, and a number of organizations had appeared dedicated to eradicating alcohol from the merchant marine and navy.⁹ The Port of London Society (later the British and French Sailors Society) had been active since 1818, and the Religious Tract Society distributed pamphlets throughout the fleet. Evangelical Christians, the driving force behind the movement, believed alcohol was not just a threat to physical health but a moral threat as well, endangering the stability of the family and by extension the security of the nation and empire.

The Royal Navy's medical personnel agreed with the concerns of the temperance campaigners. A large number of medical personnel were interviewed by the committee with

most agreeing that any reduction would "tend much to the health, strength and comfort of the ship's company..." and that drunkenness contributed to insubordination, quarreling and crime.¹⁰ The navy concurred, and a further reduction was implemented with the help of healthier substitutes such as tea, cocoa and coffee, plus monetary compensation.

As we have seen, clothing and alcohol reforms were implemented with significant medical input. While these reforms marked a tacit recognition of the growing influence of scientific medicine, the Navy Commissioners' enthusiasm to keep Jack fit was equally inspired by "the shortage of the beast rather than sincere regard for his welfare or by the efforts of some well-meaning medical man."¹¹ Despite what the admirals thought, however, their surgeons were certainly aware of their worth and willing to fight for fairer treatment. In 1858, the medical lobby had finally convinced London that a registry of qualified physicians and surgeons should be established. The Medical Act not only monopolized medicine, it also created lucrative opportunities for private practice that would keep medical men far away from the poor prospects of na-

7. House of Commons Parliamentary Papers [2469], Report of the commissioners appointed to inquire into the best means of manning the navy, together with the minutes of evidence and appendix (London: George E. Eyre and William Spottiswoode, 1853), 116.

8. John Laffin, *Jack Tar: The Story of the British Sailor* (London: Cassell, 1969): 88.

9. Mary A. Conley, "You don't make a torpedo boat gunner out of a drunkard: Agnes Weston, Temperance, and the British Navy," *The Northern Mariner* 1 (January 1999): 3.

10. House of Commons Parliamentary Papers [1174], Report of the committee appointed to inquire into the expediency of diminishing the present quantity of spirits served out daily to the seamen in the Royal Navy (London: William Clowes and Sons, 1850), 85-87.

11. John Laffin, *Jack Tar*, 102.

val service.

The Act recognized only 11,800 physicians and surgeons for the entire country, while the appearance of steam navigation companies servicing the empire offered better opportunities for seagoing practitioners. Outbreaks of cholera aboard ship during the Crimean War further exposed the shortcomings of naval health, while ashore trade publications such as the *British Medical Journal* and *The Lancet*, backed by the powerful Royal College of Physicians and Surgeons, campaigned for naval medical reforms. The Admiralty could refuse no longer, and a committee appointed to investigate the matter concluded that sufficient medical graduates could only be attracted with better accommodations, higher pay and more opportunities for promotion.¹² By Order in Council issued July 1866 Assistant Surgeons, Staff Surgeons and Inspector Generals were all granted pay increases, while Assistant Surgeons were also given the right to a private cabin. Further reforms would follow in naval hospitals and naval medical education, and while the surgeons could look forward to a better future in the service, lower-deck sailors would benefit from a much higher quality of medical provision than at any time before. At least while they remained in the Navy, Jack Tar would have access to better "health care" than almost every other working-class member in the country.

By this time the experimental auxiliary vessels had given way to advanced ironclad warships. More powerful steam engines would soon provide crews with better ventilation, fresh food, refrigeration, clean water and other amenities that would improve living standards and health aboard ship. However, it is important to note that technology merely provided the means to implement reforms that were impossible to provide in sailing ships, and which had been recognized as important by hygienists and physicians earlier in the century.

CONCLUSION

The reforms described above are only some high profile examples from this transformative period, most of which served to homogenize crews into disciplined and professional naval ratings that replaced the patchwork crews of Lord Nelson's navy. John Keegan wrote that the British sailors of the Napoleonic Wars were loyal to the sea before the navy, having spent more time as fishermen or merchant mariners than men of war. In the transition fleets of the Victorian era reforms aimed at improving standards of health and hygiene conveniently doubled as a tool of homogenization and control. The Royal Navy no longer had any need to resort to the lash: now its sailors were fixed to contracts; closely monitored by better surgeons; kept to rigid standards of fitness and hygiene; and assimilated with uni-

form clothing and kits, all of which served to relentlessly hammer crews into disciplined and cohesive bodies that would only ever know the navy. This new lower-deck, however, was not unthinking and servile. Better standards of health and fitness, training, literacy, and technical proficiency had fostered a new sense of professionalism and pride, and sailors' activism along trade unionists lines (without the strikes) became a powerful force for change before the First World War.

ABOUT THE AUTHOR

John Matchim holds a BA (Political Science) and an MA (History) from Memorial University, St. John's, Newfoundland, Canada. He was recently a CIHR-funded research assistant working on an aspect of the medical history of Newfoundland. He is interested in civil-military relations and the history of Newfoundland and "Labrador in the First World War."

12. House of Commons Parliamentary Papers [515], *Medical Officers (Army and Navy)*, (London: Her Majesty's Stationary Office, 1866).

CAPT Robert Koffman and the Genesis of the Mobile Care Team

By COL Richard Ginn, MSC, USA (Ret.)

In the fall 2011 issue of The Grog, we described difficulties faced by Navy and Marine Corps Individual Augmentees (IAs), and in this spring's issue we drew from an interview with Captain Robert Koffman, MC, to describe his medical and military training and experience as a Navy psychiatrist. Those articles come together in this issue with an exploration of CAPT Koffman's role in the genesis of the Medical Care Team (MCT), a concept that is currently deployed in Afghanistan in its sixth iteration. The MCT is a valuable contribution to our arsenal of medical support of combat operations. It is an important story.

As the war in Iraq and Afghanistan continued, the Navy was increasingly called upon to augment personnel shortages in Army deployed units with IAs, sailors who traveled to their assignments on temporary orders. Typically, they went to these assignments alone, joined their assigned units as strangers where they might be utilized in duties other than their specialty, and returned alone to their home base. As time went on the number of sailors deployed in this fashion climbed. By September 2011, there were over 15,000 active duty and Reserve IAs assigned to Army, Marine Corps, and in some cases, Navy units in Iraq, Afghanistan, Cuba, the Horn of Africa and the United States.¹ The IAs became in effect “a lost battalion” as they were essentially a hidden population. Unfortunately, as a group they became particularly prone to the perils of combat and operational stress.

The personal experience of one IA provides insight into the challenges faced by others. HM1 Thor Wold, as an HM2 in 2005, was one of 25 sailors from his stateside Navy hospital assignment who deployed to Anbar Province in Iraq with the 3rd Battalion, 25th Marines. “The 3/25 had a pretty rough go of it. We had about 48 KIA, and I think 340 wounded. We didn't have a lot of caregivers, and a lot of our corpsmen were getting hurt too. There were very few of us that got through that year or two afterwards unscathed in some way, fashion, or another. Every one of us, to a man, every one of us had bad PTSD; a lot of us had TBIs.”² Yet upon their return home, these sailors felt cut adrift. “Our command had no clue what to do with us; my commanding officer, my executive officer, no one had a clue what to do with us. All they thought when we got back was, ‘Okay, you did your deployment; you're back now, why do you

guys have attitude problems.” The sense of isolation for these returning IAs was demoralizing. By and large their reception was “Welcome back. Go back to work.”

As the U.S. presence in Iraq grew, the challenges for the IA population began to be recognized, and CAPT Koffman was a key player in bringing this to light. His experience with combat and operational stress, that began in 1991 with Iraqi soldiers captured in Operation Desert Storm, and expanded in multiple deployments to Iraq beginning in 2003, led to his appointment as the Combat and Operational Stress Consultant for the Surgeon General, as well as the first Director of Deployment Health. In this role, Koffman was increasingly dismayed by the IA situation. To begin with, these sailors who were sent alone to strange units, were often “re-missioned” and not afforded the support gained from unit membership.

1. Bettios, Iona N., CAPT, IA Deployment Support and Readiness, M92, BUMED; Email Msg 23 Sep 2011, Subj: Deployment After Action Reports.

2. This and other quotations are from a BUMED Oral History Project interview with CAPT Robert L. Koffman, MC, on several occasions from October 2010-February 2011. Other primary sources are the BUMED oral history interviews with LCDR Justin S. Campbell, Ph.D., MSC, 12 October 2011; and CDR Alan F. Nordholm, Ph.D., MSC, 8 August, 2012.

He argued that this was a recipe for failure, since “there is abundant anecdotal evidence that the camaraderie and cohesion that an organic unit provides are protective, and now there is also data that proves that.” He concluded that IAs were being set up for unintended consequences. “Without all of those things, particularly in a chaotic, combat environment where the Army’s needs are so many, a Navy individual augment may be reassigned or re-missioned two or three times in a particular deployment. We are contributing to a lot of unnecessary psychological burden.” The IAs were simply falling through the cracks, and because their deployments were in small numbers, “it makes the IA all the more vulnerable.”

CAPT Koffman became the “IA Advocate”, a persistent and persuasive voice for this population, and he took their case to the senior Navy leadership. As he told Admiral Johnathan Grennert, then Vice Chief of Naval Operations, these sailors bore a special burden. “The Navy needed to look in on the IAs that are being sent down-range, not because the Army is taking bad care of them; it’s just people don’t understand the importance of cohesion, of identification, of camaraderie. The support that an individual receives in combat, both battle-buddy as well as foundational fundamental support, is probably the single-most protective aspect of combat.”

In the fall of 2009 it became clear that

there was a significant mental health crisis within the staff of the Bagram Theater Internment Facility, a detainee camp in Afghanistan. CAPT Koffman organized a mental health Medical Care Team (MCT), consisting of himself as OIC, and (then) LT Justin Campbell, MSC, a research psychologist, as operations officer. They deployed to Afghanistan in December to “conduct behavior health surveys and focus groups from multiple Navy units while in Afghanistan. The data will be analyzed on site at the unit, as opposed to the individual level, and will provide an overall mental health snapshot for the unit’s leadership to help mitigate the stressors of a combat deployment.”³ It was necessary to get a handle on the size of the problem, and for this the team utilized the Behavioral Health Needs Assessment Survey (BHNAS), a survey instrument developed by the Naval Health Research Center in San Diego.

They administered the BHNAS at the Bagram facility, and their findings dramatically demonstrated that there was an urgent need to do something for those IAs who were not doing well. As Campbell put it, “when we got our data together, it was pretty clear that they had run off a cliff. We had never seen PTSD scores like that before.” Due to the urgency of the situation, Koffman and Campbell quickly moved beyond their survey efforts into providing urgently needed on-the-spot psychological health support for the sailors they

had identified as encountering adverse effects of combat or operational stress. At the same time, they communicated their findings to leaders who were in the position to support and facilitate command actions to resolve the problems in this unit.

The development of the MCT as a small, rapidly deployable team of professionals inserted into a theater of operations to conduct mental health assessments of units then quickly communicate those findings to leaders, is an example of “actionable psychology”. The usefulness of this innovation is demonstrated by the five teams that have deployed since 2009, including MCT-6, which is currently in Afghanistan. A typical team today includes five members, including a research psychologist as analyst, one or two social workers or clinical psychologists, in some cases a chaplain, and a corpsman in the psychology technician rating. As the Army expanded its mental health treatment capability with the establishment of Combat and Operational Stress Control (COSC) clinics throughout Afghanistan, the expedient need for the initial MCTs to shift to a therapeutic role ended, since later teams could arrange for care of urgent cases by the supporting COSC clinic in that area.

The success of the MCT in its capability to quickly take the mental health “temperature” of deployed units and individuals and to provide immedi-

3. “Navy Mobile Care Team Supports Mental Health in Afghanistan,” *Navy and Marine Corps Medical News*, No. 11, 13 November 2009.

ate feedback to commanders is part of the larger story of the need for battlefield mental health support. This is an important military medicine lesson of the "Long War." The question is what will be available in the future, since these teams are ad hoc and not part of the standard array of "plug and play" Navy units. Perhaps more importantly, will the lessons learned during this war

be remembered in future engagements when the memories of this period have faded? One of the principle objectives of our Navy Medicine Oral History Project is to ensure that lessons learned today are documented and available to future generations. Those will include the special value of mental health MCTs in future engagements when sailors are plucked from their regu-

lar Navy assignments to fill urgent requirements elsewhere in a deployed joint U.S. force.

ABOUT THE AUTHOR

COL Richard "Dick" Ginn is a retired Army Medical Service Corps Officer who serves as an oral historian with the Navy Medical Department.

Navy Medicine says it's final goodbye to the Potomac Annex



Months after the Bureau of Medicine and Surgery (BUMED)'s "Change of Port" ceremony and the relocation of personnel to the Defense Health Headquarters and the BUMED Detachment in Falls Church, VA, the long goodbye has ended. On 24 July 2012, following a thorough inspection of the campus by personnel from BUMED Headquarters and Naval Support Activity, Washington (NSA-W), the Naval Support Facility, Potomac Annex was officially turned over to NSA-W.

In essence, this day marked the convergence of historical eras—the past (1844 to 2012) and the future (2012 and beyond). For the last 168 years, the Potomac Annex has served as a stage for the Naval Observatory (1844-1893), Naval Museum of Hygiene (1894-1905), Naval Medical School (1902-1942), Naval Hospital Washington (1906-1942), Naval Dental School (1923-1942), and its longest tenant, BUMED (1942-2012). The Navy's departure opens up a new era to be filled by the Department of State.

A fond, final farewell to the old Potomac Annex. Let us remember it has served the Navy well over the years.

CAPT P. Paul Toland, Jr., BUMED HQ Director for Administration, and CDR David A. Varner, Commanding Officer of Naval Support Activity Washington. from 24 July 2012. This photo was taken after staffs from BUMED HQ and NSAW completed a thorough walk-through of the Potomac Annex Campus.

Courtesy of CDR Jason Spencer, MSC, USN



Notes on the First Women in the Navy Dental Corps

World War II spurred on a growth in Navy Medicine that has never been matched. By the end of the war the Navy Medical Department was represented by a total of 168,100 physicians, nurses, corpsmen, dentists, and health care specialists (Hospital Corps Officers). The Dental Corps alone was comprised of 7,012 active duty and reserve dentists. Of this population only two (or .029 percent) were women—LT Sara Gdulin Krout and LT(jg) Alice Elizabeth Tweed.

Sarah Gdulin Krout, a native of Riga, Latvia, emigrated to the United States in 1920 after graduating with a degree in dental surgery from the University of Latvia and serving briefly with the Red Cross. She continued her education at the University of Illinois and then began practicing in Chicago beginning in 1928.

When Dr. Krout entered military service in 1943, the Navy had only begun permitting women to serve in the naval reserve (Women Accepted for Voluntary Emergency Service or WAVES) since August 1942. Although qualifications were the same for both men and women, WAVES officers were not allowed to be married to other naval officers, they could not have children under the age of 18, and they could only serve within the Continental United States.

At the time, LT Krout was married to an Army psychologist (Maurice Krout), and had a daughter that was exactly 18 years old (Johanna). Her first assignment as a WAVES was the Naval Training Center, Great Lakes. She served two years on active service before entering reserve duty. She would continue to serve, albeit in the Reserves until 1 December 1961, when she was forced to retire on account of age. In doing so, she earned another distinction: first woman to retire from the Dental Corps. Krout continued to practice dentistry in Cook County, IL, into her seventies. She passed away in Evanston, IL, on 30 May 1989 at the age of 90.

Elizabeth Alice Tweed was born in Ray, AZ, on 5 May 1920, and graduated from the University of Southern California School of Dentistry in 1943. She was commissioned as a lieutenant junior grade on 28 April 1944. From 14 August 1944 to July 1946 she served at Naval Hospital San Diego, CA. She continued to serve in the Navy Reserves until 30 October 1950 when she became the first female Navy dentist to resign. In 1950, she married civilian dentist Dr. Joe Dayton Peak and began a family. She died on 25 April 2011 in College Station, TX at the age of 90.



LT Sara Krout, DC, USNR



Dental officers attending a short course in prosthodontics at the Naval Dental School, 1967.

All photos from BUMED Archives

Navy Prosthodontics: A Historical Perspective

The year is 1912. The President is William Howard Taft. In January, Robert Scott ironically and tragically reached the South Pole and New Mexico became the 47th state. February saw the first submarine commissioned in the U.S. Navy at Groton, CT, and Arizona became the 48th state. The flag would not change for another 47 years. The RMS *Titanic* sank off of Greenland and Boston's Fenway Park opened in April. In August, the U.S. Marines invaded Nicaragua and a small piece of congressional legislation was passed creating a Dental Corps within the United States Navy.

What was dentistry like in 1912? There was no composite resin. There were no standardized denture teeth. The porcelain fused to metal crown would not appear for at least 50 more years. Denture acrylics were 25 years away. Electric handpieces were relatively new- reaching speeds of 3000 rpm! A fledgling company named the Dentist's Supply Company of New York was just starting. Dentistry in the United States consisted of Restorative dentistry, Removable Prosthodontics (and to a much lesser extent Fixed Prosthodontics) and Exodontia. The term Prosthodontics was often used in the literature but there were no recognized Dental specialties in the United States.

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In February 1923, The Naval Dental School opened in Washington, DC. The purpose of the school was to provide postgraduate education for Dental Officers, this education was not specialty training. It also provided the opportunity for Hospital Corpsman to train as dental assistants and dental hygienists. The Central Dental Laboratory for the Navy was also located at the school. Courses for Dental officers included dental prosthesis, clinical dentistry, minor oral surgery, dental radiology, metallurgy, bacteriology and others.

It wasn't until after the Second World War that Dental specialties came into existence. Oral Surgery was the first recognized specialty in the United States in 1946, followed by Prosthodontics in 1947 and Periodontics in 1949. In 1953, there were 1,886 Dental Officers on active duty. At this time there were 36 Dental Officers who are certified by specialty boards, sixteen of these were Prosthodontists. This high regard for board certification is still prevalent in Navy Prosthodontics. In research, advances in in-

strumentation, metallurgy and castability, ceramics, engineering and maxillofacial prosthetics are known throughout the world. In addition, Navy Prosthodontics has made a huge contribution to Navy dentistry in leadership and has helped shape the specialty and the way it is practiced. Developments in complete dentures, removable partial denture design and principles, fixed prosthodontics and implantology that are Navy developed are taught in almost every Dental school. The scientific literature in Prosthodontics by Navy authors is extensive. Many significant leaders have been Prosthodontists, such as RADM Alfred Chandler. Admiral Chandler was in the first class at NPDS in 1923. As Chief of the Corps (1946-48), Admiral Chandler gained autonomy from the Dental Corps from the Medical Corps shortly after World War II. He was one of the first group of diplomates of the American Board of Prosthodontics. He was later President of the American Association of the History of Dentistry. RADM Robert Elliott was a strong leader and as Chief



of the Dental Corps prevented the Naval Post Graduate Dental School from being moved from Bethesda to a centralized schools Command in Florida. He later taught at Georgetown University. This strong leadership by Navy Prosthodontists continues today. The specialty has always had a dominant role in education and development. Dr Robert Lytle pioneered the area of tissue conditioning and was the Chair at

Georgetown University after retirement. He was also President of the American Board of Prosthodontics. Dr. James Kratochvil developed design philosophies for distal extension RPD's and was later Chair at UCLA. Dr. Robert Leupold and John Holmes are known for popularizing the altered cast technique. Dr. Leupold was Chair at the University of Maryland and Dr. Holmes at UCSF. Dr. Gene King helped pro-

mote the idea of the rotational path RPD and was at M.D. Anderson. The list of educators that are retired Navy and in Dental Schools are extensive. Dr Richard Grisius was President of the American Board of Prosthodontics and the AAMP. He also was Program Director of the residency at Georgetown University. Dr. H.J. Towle helped develop the artificial eye and unique breast replacement techniques. He was



DENTAL PROSTHETIC LABORATORY - RECRUIT PROSTHODONTIA DISPENSARY
TRAINING CENTER - FARRAGUT, IDAHO - 12 DECEMBER 1944
CAPACITY 2,500 DENTAL PROSTHETIC UNITS PER MONTH

also at Georgetown. Drs. Jim Lep-ley and John Stoll were at Memorial Sloan-Kettering and UCLA respectively. Dr. Davis Henderson was co-editor of McCracken's Removable Partial Dentures and an educator for many years. Other great educators include Dave Firtell, Walt Derner, Walt Dann, Arthur Frechette, Noel Wilkie. There have been six ex-Navy Prosthodontists that were Presidents of the American College

of Prosthodontists. Nine have been Board Examiners. Implantology was introduced to the Navy Dental Corps from Sweden by Bob Flinton and Jim Mellonig in 1983. Dr. Robert Taft is the first board examiner on active duty for the American Board of Prosthodontics. The list of Prosthodontist's accomplishments and laurels are long and this leadership and sense of commitment continues. Navy Prosthodontics will

continue to play a leading role as the Dental Corps enters its second century.

This article was prepared by Dr. Robert Leupold and CAPT Kathleen Kenny, DC, USN for the Dental Corps Centennial Book.

Navy Oral Medicine: A Historical Perspective

Although Oral Medicine has been around since the dawn of Navy dentistry, Navy Oral Medicine specialists only began appearing in the Navy Dental Corps in the early 1960s. At the time they were classified with the primary specialty code of “Oral Diagnostician.” These Oral Diagnosticians were generally assigned to the Naval Dental School in Bethesda to contribute to the various training programs that existed there at that time and to Naval Training Stations and Marine Corps Recruit Depots, where their highly developed diagnostic skills were used to clinically evaluate large volumes of recruits. According to existing records, some of these early Navy Oral Medicine specialists received training in the 1 year Oral Medicine program started at the Naval Dental School in the early 1960s, but several others did so in various civilian universities, such as the University of Iowa, the University of Michigan and Indiana University.

In 1971, under the leadership of one of these pioneers, CAPT William K. Bottomley, the newly re-named Naval Post Graduate Dental School established a formal two-year in-service training program in Oral Medicine leading to board eligibility by the American Board of Oral Medicine, the specialty’s national professional organization.

Over the next 35 years, 36 dental officers completed the Oral Medicine residency at Bethesda, with an amazing 100% of graduates challenging the boards, resulting in a 94% pass rate. These Navy dental officers went on to various fleet assignments, with many achieving significant leadership positions. After having left the Navy, many of these officers went into academia and hospital dentistry, and experienced similar success in the civilian world, to include deanship of a dental school, various chairmanships and presidencies of the American Academy of Oral Medicine.

In the turbulent era of the early 21st century, as manning and operational policies and requirements underwent several significant changes, the era of the Navy Oral Medicine specialist came to an end. In 2006, the Naval Postgraduate Dental School graduated its last fully trained Oral Medicine specialist. However, it was clear that the need to capitalize on diagnostic enhancements in the field of dentistry did not disappear; it had just migrated to the newly recognized specialty of Oral and Maxillofacial Radiology.

In a bold and visionary manner, one of the last traditional Oral Medicine Specialty Leaders, CAPT Lee Prusinski advocated for and championed an initiative to begin sending Navy dental officers to civilian

universities to undergo a rigorous three-year residency in Oral and Maxillofacial Radiology, with an eye towards forming a community of fully-trained, boarded specialists to meet the diagnostic needs of the future Naval Force. Starting in 2008, the Navy Dental Corps began sending one dental officer a year to a civilian program. In June 2011, the first fully trained Oral and Maxillofacial Radiologist graduated from residency at the University of Texas Health Science Center at San Antonio, reported to the Naval Postgraduate Dental School, assumed the specialty leader role, and began shepherding the community and providing cutting edge diagnostic support to the beneficiaries of Navy Medicine.

Prepared by CAPT Sean Meehan, DC, USN for the Dental Corps Centennial Book.

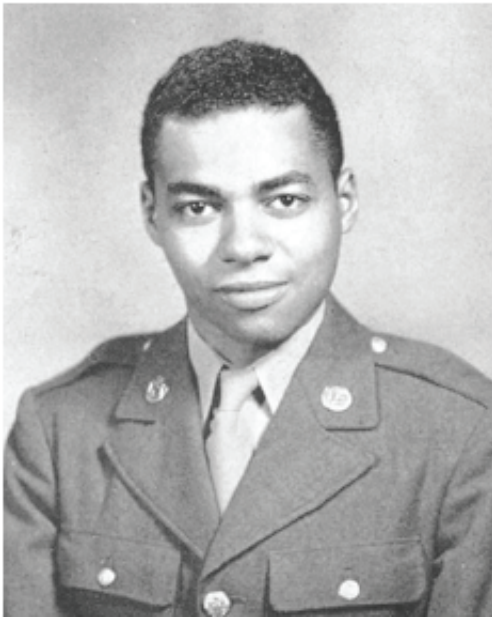
Notes on African-Americans in the Navy Dental Corps

By CAPT Armstead Galiber, DC, USN (Ret.)

CAPT Langston Smith, DC, USN (Ret.)

CAPT Nathaniel Bryant, DC, USN (Ret.)

The information in this article was gathered primarily through recollections of Naval Dental Officers. Its purpose is to acknowledge one of many paths of diversity in the Navy Dental Corps.



Dr. Tobias Watkins, the first African American in the Navy Dental Corps.

Photo courtesy of authors

According to dental historian John M. Hyson, Jr., D.D.S., we know that Lieutenant Junior Grade Thomas Watkins, Jr., was the first African-American dentist to be commissioned in the Dental Corps. He was a graduate of the University of Pennsylvania, class of 1944, and reported for duty on 1 November 1944. He was the son of Thomas Watkins, Sr., DDS, of Charlotte, NC, a 1909 graduate of Howard University Dental Department. Watkins was released from active duty in November 1946 and retired from the U.S. Naval Reserves on 1 September 1966.

Dr. Thomas Leslie James was the first African-American dental officer to retire from the Navy. He was a graduate of Meharry Dental School and received his commission on 14 April 1951. He served most of his years with the Fleet Marine Force and always considered himself a Marine. On 1 July 1966, he retired as a Commander.

CAPT Nathaniel Bryant, DC, USN (Ret.) met Dr. Thomas James in 1976. Captain Bryant credits Dr. James with convincing him that the Navy Dental Corps was a better op-

tion than private practice. CAPT Bryant remembers hearing the stories of Dr. James' naval experiences and stories of Dr. James' brother, General "Chappie" James, the first African-American Air Force Flag Officer.

The presence of African-Americans in the Navy Dental Corps remained very small from the 1950's to the late 1970's. It is reported that most who came into service during this time did not stay beyond their initial tour of duty. Many transitioned to the Reserve Corps. Among those pioneers is Captain Hamil Willoughby who accepted his commission in 1966 and retired from the Reserve in 2004. According to photos displayed at the Naval Post Graduate Dental School in Bethesda, MD, CDR R. C. McMurdock, Class of 1970, was their first African-American graduate. CAPT John Anderson graduated the following year and is reported to have served in the Bureau of Medicine and Surgery during the later part of his career.

In 1977, there was a surge in the numbers of African-Americans accepting commissions in the Navy

Dental Corps. In this group of 8 were Drs. David Moore, Langston Smith, Cyrus Pettis, Mary Nelson, Yvonne Marzett, Eric Lewis and Tom Hawkins. This surge continued in 1978 with Drs. Armstead Galiber, Austin and Kathy Maxwell, Clarence Miller and Robert Frisby. These Navy dentists, and those that followed soon after, formed a vanguard of officers who communicated and networked with one another to promote their growth, development and involvement in all aspects of Navy Dentistry. Recruiting and retaining African-American dentists was also a major goal. They realized that seeing a senior African-American dental officer was a rare occur-

rence. It is reported that only five African-Americans were on active duty when the surge began in 1977: A.V. Hill, Marty Walton, Cleo Walker, Lenny Goins and Isaiah Sharpe. The result of the networking effort reached a zenith in 2004 when there were 22 African-American Dental Corps Captains on active duty.

ABOUT THE AUTHORS

CAPT Armstead L. Galiber, DC USN (Ret) received his dental degree from Howard University College of Dentistry Class of 1976. He retired from the Navy Dental Corps in 2007 and currently practices dentistry at the Walter Reed National Military Medical Center, Bethesda MD.

CAPT Langston D. Smith, DC USN (Ret) received his dental degree from the University of Kentucky in 1977. He retired from the Navy Dental Corps in 2007 and is currently Chairman of the Endodontic Department at Howard University's College of Dentistry in Washington, DC.

CAPT Nathaniel C. Bryant, DC, USN (Ret) received his dental degree from Meharry Medical College School of Dentistry in 1981. He retired from the Navy Dental Corps in 2011 and resides in Virginia's Tidewater Area.



When he graduated from the Naval Postgraduate Dental School in June 1970, CDR R.C. McMurdock earned the distinction of the first African-American to do so.

BUMED Archives

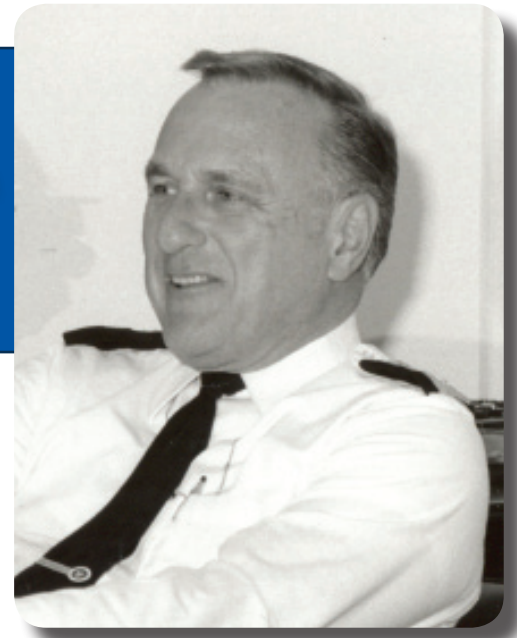
Whether in CONUS, OCONUS, at sea or with the Marines, African-American dental officers have served with distinction. Those recognized in this article are just some of many who left a pioneering legacy in their wake.

- First Dental Officer.....Thomas Watkins Jr.
- First Retired Dental Officer.....Thomas Leslie James
- First female Naval Scholarship Officer.....Mary Nelson
- First female to receive a direct commission.....Yvonne Marzett
- First male promoted to Captain.....A.V. Hill
- First female Captain.....Cathy Rearden
- First selected for Commanding Officer.....Langston Smith
- First Company Commanding Officer.....Armstead Galiber (2nd Dental Company, 2nd Dental Battalion 2rd FSSG, Camp Lejune, NC July 1993-96)
- First NDC Commanding Officer.....Langston Smith (Navy Dental Center Northwest Bremerton, WA, 1999-2002)
- First Battalion Commanding Officer.....Kenneth Wright (2nd Dental Battalion Okinawa, Japan 1999-2002)
- First Director, Navy Postgraduate Dental School.....Andre Santos
- First to serve the First Family.....Austin Maxwell
- First Detailer.....Cecil White
- First Dental Officer Headquarters Marine Corps....Kenneth Wright
- First graduate of NPDS..... CDR R. C. McMurdock (June 1970)

Vixerat

Rear Admiral Richard "Dick" Shaffer (1934-2012)

Ancient Romans preferred to avoid the allusion to death. In referring to someone who had recently died, they would use the Latin term "vixerat," meaning "He has lived." RADM Richard "Dick" G. Shaffer, the beloved former Chief of the Navy Dental Corps, passed away on 18 July 2012. He was 77. With his death we are reminded that he certainly had lived a meaningful existence.



A native of Lakewood, OH, Admiral Shaffer graduated from Ohio Wesleyan University in 1956, The Case Western Reserve University School of Dentistry in 1960, and The George Washington University in 1978. He entered the U.S. Navy as an intern in 1960 and was assigned to various ship and shore stations in the U.S. and overseas. He completed a residency in General Dentistry at the Naval Dental School Bethesda, MD in 1970, and again returned to the School as Director in 1975.

In an 1989 interview with *Navy Medicine Magazine*, RADM Shaffer admitted that he served in all the "fun billets" the Navy Dental Corps offered in his 28 years of service.

"I've served aboard two ships, been stationed at the Naval Academy and overseas in Panama and Spain. I had command of the clinics at Great Lakes and Norfolk. I have been a fleet dental officer, and I feel somewhat unique and privileged to have been the first dentist to have commanded a geographic region and the only nonphysician to have command the National Naval Medical Center."

From 1984 to 1989, Shaffer was a dentist wearing many hats. In 1984, he was selected to command the National Capital Region and oversee responsibility for the "President's Hospital" at Bethesda, MD, plus health-care in 5 states. In September 1984, Dr. Shaffer was also appointed as the Chief of the Navy Dental Corps and Assistant Chief of the Bureau and Surgery for Dentistry. He wore these hats until his retirement on 1 February 1989.

Former colleague RADM Bob Birtcil remembered Shaffer as a man with a "presence" about him. "He had a larger than life persona and a charismatic aura. He was one of the greatest leaders in the history of the Dental Corps."

Above all RADM Shaffer was a man who cared about the Dental Corps he served in and represented even in his retirement. He once commented that serving in the Dental Corps was a unique privilege. "The Dental Corps is like a family unit and it's been that way since 1912. You never lose your identity as a Dental Corps officer." For the Dental Corps and the rest of Navy Medicine, Shaffer will be remembered as an important part of its identity.

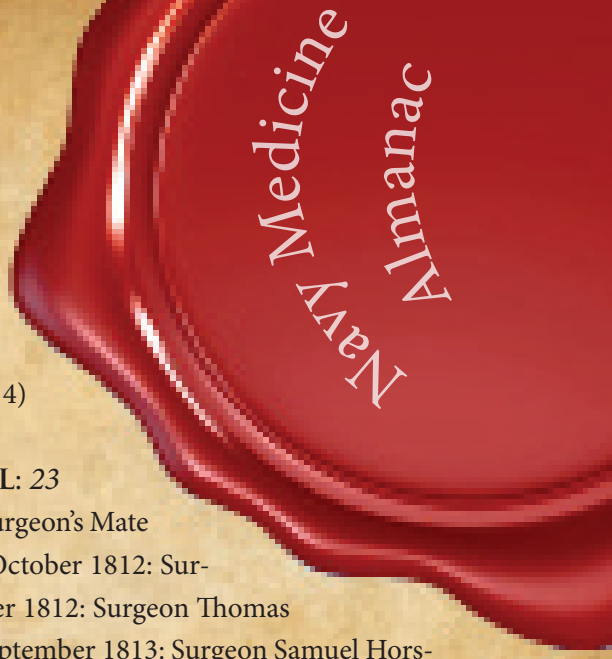


PORTRAIT OF SURGEON USHER PARSONS, USN (CA. 1812)

Surgeon Usher Parsons the sole medical person aboard USS *Lawrence* at the Battle of Lake Erie, was singlehandedly responsible for the care of 96 wounded sailors.

Courtesy of Brown University Archives

War of 1812



MEDICAL PERSONNEL: 52 (1812)/91 (1814)

(26 surgeon's & 26 surgeon's mates in 1812/44 surgeons & 47 surgeon's mates in 1814)

COMMENDATIONS AWARDED TO NAVY MEDICAL PERSONNEL: 23

(USS *Constitution*, 19 August 1812 and 29 December 1812: Surgeon Amos Evans, Surgeon's Mate John D. Armstrong, and Surgeon's Mate Donaldson Yeates; USS *United States*, 25 October 1812: Surgeon Samuel R. Trevett, and Surgeon's Mate, Samuel Vernon; USS *Wasp*, 18 October 1812: Surgeon Thomas Harris and Surgeon's Mate Walter W. New; USS *Lawrence*, Battle of Lake Erie, 10 September 1813: Surgeon Samuel Horsley and Surgeon Usher Parsons; USS *Niagara*, Battle of Lake Erie: Surgeon Robert R. Barton; USS *Enterprise*, 4 September 1813: Surgeon Bailey Washington; USS *Hornet*, 24 February 1813: Surgeon's Mate Micajah Hawkes and Acting Surgeon Charles Cotton; Battle of Lake Champlain, 11 September 1814: Surgeon William Caton and Surgeon's Mate Gustavus R. Brown; USS *Peacock*, 29 April 1814: Surgeon Charles B. Hamilton and Surgeon's Mate Thomas Cadle; USS *Wasp*, 28 June 1814: Surgeon William M. Clark; USS *Constitution*, 20 February 1815: Surgeon James A. Kearney, Surgeon's Mate Benjamin Austin and Surgeon's Mate Artimus Johnson; USS *Hornet*, 23 March 1815: Surgeon Benjamin M. Kissam and Surgeon's Mate Samuel M. Kissam.)

DUTY STATIONS:

Hospitals/Other Medical Facilities: 15*

(Permanent Navy hospitals were still over a decade away; all Navy hospitals at the time were makeshift and temporary facilities located on or near Navy yards in Brooklyn, NY, Charleston, SC, Erie, PA, New Castle, DE, New Orleans, LA, Newport, RI, Norfolk, VA, Philadelphia, PA, Portland, ME, Sacket's Harbor, NY, Savannah, GA, St. Mary's, GA, Sunbury, GA, Washington, DC, and Wilmington, NC.)

Vessels (non-gunboat):

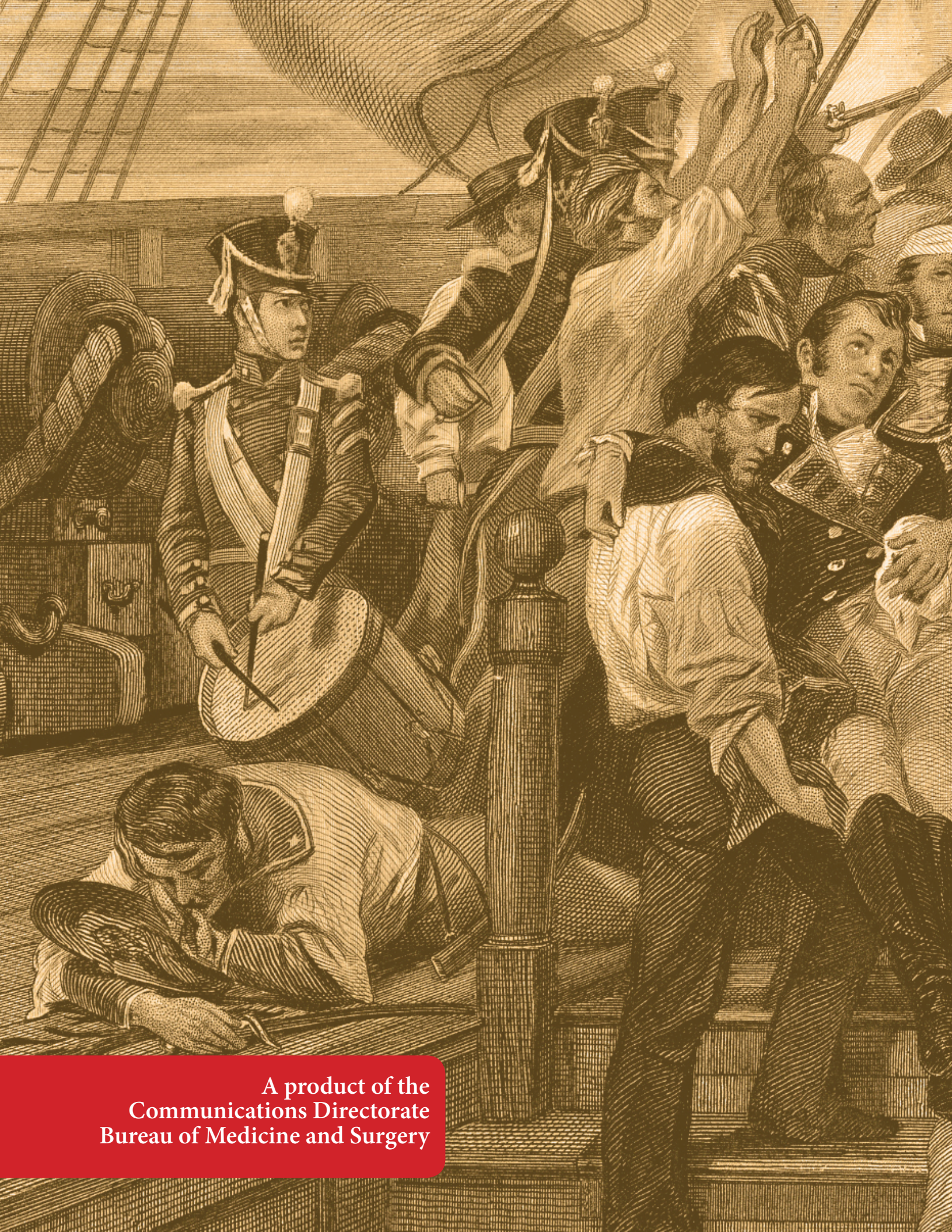
FRIGATES: *Adams*, *Chesapeake*, *Congress*, *Constellation*, *Constitution*, *General Greene* (Receiving Ship), *Guerriere* (formerly HMS), *Java* (formerly HMS), *John Adams*, *Macedonian* (formerly HMS), *Mohawk*, *President*, *Superior*, *United States*

SLOOP-OF WAR: *Alert* (formerly HMS), *Bulldog* (renamed *Eagle*), *Contractor* (renamed *Trippe*), *Commodore Preble*, *Detroit*, *Eagle* (formerly *Bulldog*), *Epervier* (formerly HMS) *Erie*, *Fairplay*, *Frolic*, *General Pike*, *Hornet*, *Little Belt* (formerly HMS), *Louisiana*, *Madison*, *Peacock*, *Saratoga*, *Scorpien*, *Trippe*

BRIG: *Argus*, *Caledonia*, *Enterprise*, *Feret* (renamed *Viper*), *Georgia*, *Hunter* (formerly HMS), *Lawrence*, *Linnet* (formerly HMS), *Niagara*, *Oneida*, *Siren*, *Rattlesnake*, *Troup*, *Viper* (formerly *Ferret*), *Vixen*

SCHOONERS: *Alligator*, *Ariel*, *Asp*, *Catherine*, *Chippewa*, *Comet*, *Conquest*, *Fair American*, *General Tompkins*, *Growler*, *Julia*, *Hamilton*, *Lady of the Lake*, *Lady Prevost* (formerly HMS), *Nautilus* (first ship lost in the War, 6 July 1812), *Nonsuch*, *Ohio*, *Ontario*, *Pert*, *Porcupine*, *Queen Charlotte* (Formerly HMS), *Raven*, *Revenge*, *Scorpien*, *Scourge*, *Somers*, *Sylph*, *Tigress* (formerly HMS)

* Not counted in this total are two aid stations that were set up in Rockville, MD. Following the Battle of Bladensburg (24 August 1814), Surgeon Edward Cutbush, Officer-in-Charge, Naval Hospital Washington, sent two Navy physicians (Surgeon's Mates John Brereton and John Harrison) to render aid to soldiers and Marines. Navy "field" hospitals were established at Adam Robb's Tavern and the Montgomery Court House.



A product of the
Communications Directorate
Bureau of Medicine and Surgery