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COVER: The battle for Iwo Jima resulted in over 28,000 U.S. casualties before the island was finally secured in March 1945. The recollections of a hospital corpsman who cared for the wounded appears on page 29. "A Warrior Homeward Bound," painted by William F. Draper, is from the Navy Art Collection, Washington, DC.

We Want Your Opinion

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

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Navy Medicine 1945



Retired Essex-class aircraft carrier USS *Intrepid* approaches the Statue of Liberty in New York Harbor, 5 December, on its way to Bayonne, NJ, for 2 years of maintenance. The *Intrepid* has served in World War II, Korea, and Vietnam and is now a museum at Pier 86 in New York City. Photo by PAC Tom Sperduto, USCG



Lights in the shape of a wasp decorate the well deck of the amphibious assault ship *Wasp* at Naval Station Norfolk, VA. During Norfolk's "Decorama" decoration contest, *Wasp* took first place in the assault ship category. Photo by D. Kevin Elliott

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

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

Send submission for consideration to Janice Marie Hores, Managing Editor, at:
jmhores@us.med.navy.mil

I look forward to hearing from you.

Department Rounds

“Navy Medicine Needs You!”

Naval Medical Logistics Command Aims to Overcome Healthcare Provider Shortage

Navy medicine is looking for doctors and nursing professionals to join more than 3,700 healthcare personnel worldwide to provide healthcare to the men, women, and family members of the Navy and Marine Corps team.

Naval Medical Logistics Command (NMLC) contract hires won't be deploying, but will serve their country on the home front. As contract hires, providers will administer healthcare in a Navy hospital or a Navy clinic in the U.S. “One of the big advantages of this program is that providers can serve their country and support the war effort,” said Andrew Muenzfeld, Naval Medical Logistics Command's director for Healthcare Services Support. “There are plenty of people out there who would take some pride in working inside the naval hospital and in some ways contributing to the overall benefit to the country—without signing up.”

Dr. Reuben Smith, a contract physician who works in the Acute Care Department at Naval Hospital Jacksonville, says it's his military background that gives this job personal meaning. “I have kindred feelings for those folks who are being deployed because I have deployed,” Smith said. “I also understand some of the issues sailors and Marines have to undergo when they are deployed, when they return, even more so.”

Muenzfeld said Navy medicine suffers the same fate as most healthcare related companies—the nationwide shortfall of physicians and nursing professionals. “In the industry, as a whole, there is a great demand for their services, but a woefully short supply of workers,” he said. “Because the military has placed so many people in the desert performing healthcare, all those people have been back-filled, using contracts.”

NMLC works with more than 200 companies to acquire the services of the healthcare providers with the desired skill sets. The command's acquisition of qualified healthcare providers is filled with other challenges, too. Besides the national shortage, there is a built-in lack of flexibility in regard to contract hires in the Navy logistics world.

“We just need to do a better job of marketing Navy medicine and Defense Department medicine as a place that people want to come to work. We have many, many wonderful attributes and we have some attributes that the private sector doesn't have,” said Muenzfeld.

Tish Ferguson, a contracted nurse at Naval Hospital Jacksonville, said her job is more rewarding than working in the civilian sector. Like Smith, she enjoys the focus of the mission and the working environment. “To me, it's more family-oriented,” Ferguson says. “We really get to know our patients and, because they are serving their country, it feels different to me. There's a camaraderie that exists here that I did not find in the civilian population. Working here, there's a sense of everybody working together. So, it's a different, a nicer environment.”

—Story by MC1 Jeffrey B. McDowell, Navy Medicine Support Command Public Affairs Office.



Dr Reuben Smith, conducts a patient examination
Photo by MC1 Jeffrey B. McDowell

PTSD Conference Held at Naval Hospital

Nightmares, flashbacks, irritability, outbursts of anger, difficulty concentrating, and increased vigilance are just some of the symptoms of Post Traumatic Stress Disorder. Many Marines and sailors are experiencing these symptoms and don't know how to get help. Even worse, some are afraid to seek help.

In an effort to ensure everyone gets the best care possible, over 80 Marines, sailors, and civilians attended a 1-day conference on Post Traumatic Stress Disorder 28 November at Naval Hospital Camp Pendleton.

The conference was co-sponsored by Marine Corps Base and the Naval Hospital to serve as a forum "to better 'get our arms' around the myriad issues associated with PTSD," said COL James Seaton, commander, MCB Camp Pendleton. Attendees were a mix of junior and senior officers, non-commissioned officers, staff non-commissioned officers, corpsmen, chaplains, military and civilian doctors, counselors, and spouses from throughout I Marine Expeditionary Force, 1st Marine Division, 1st Marine Logistics Group, Naval Medical Center San Diego, NHCP, MCB, Marine Corps Community Services and the Veteran's Administration.

According to Seaton, the purposes of the conference were to:

1. Increase awareness and communication between the various programs dealing with PTSD.
2. Identify areas where there may be gaps in coverage or a need to reinforce efforts.
3. Identify systemic issues that might currently be beyond Camp Pendleton's ability to correct and require higher level attention.
4. Discuss PTSD education efforts.

After much discussion, three issues were identified by the group as problem areas in relation to PTSD care. They are Marine Corps "culture", identification of combat stress/PTSD-related issues, and referral and treatment.

"We have to de-stigmatize PTSD or any mental illness as bad and get everyone to realize the most important thing is to get these young men and women the help they need," said CAPT Steven Nichols, commanding officer, Naval Hospital Camp Pendleton.

Some issues raised were Marines getting in disciplinary trouble (often with PTSD being recognized for the first time), not being completely honest on post-deployment health reassessment surveys, peer teasing, and the short duration between deployments with the need to retain combat-experienced personnel. Marines fear a potential career impact of having medical documentation of PTSD and a desire to avoid psychotropic drugs because of their side effects. There is also a desire for confidentiality when seeking assistance or counseling.

The conference ended with some action items identified to be done at the Base level for continued improvement of PTSD identification and treatment. They were: more advertising and education about PTSD and where to get care; expanding counseling services and holding more follow-on meetings between medical/counseling services and units.

"The conference vastly exceeded my expectations in scope and participation," said Seaton. "This is just the first step in improving care for our warriors and their families."

For more information about PTSD or to receive assistance please contact National Center for PTSD: www.ncptsd.va.gov

—Story by Douglas W. Allen, NHCP Public Affairs.

Pre-Deployment Dental Care Aids Mission Accomplishment

One of the biggest factors of being a Marine is the capability to deploy and support the Marine Corps and war fighting effort, but Marines who have not visited the dentist in more than a year can count on staying in garrison.

No matter how dreadful the dentist's office may seem, for those who want to deploy, attending their scheduled appointments is mandatory.

"It's our mission to make sure all Marines are deployable, but if they don't make their appointments there's nothing we can really do," said HN Amahaad Lee, with the Main side Dental Clinic.

Attending appointments to receive proper dental examinations within the allotted time limits is not just something required for manning documents or personnel records. Getting the proper attention before deploying can prevent future infections and complications, Lee continued.

"In the desert, Marines don't brush their teeth or floss as much as they might here," said HM3 Jamal Hawkins, also a corpsman with the clinic. "It may even be days or weeks before they attend to their mouths."

Cavities can get out of hand, which leads to root canals, Hawkins added. Untreated root canals can then lead to infection that can prevent a Marine from doing his job to the best of his ability. All in all, it benefits the Marine and his unit to get his mouth checked out before heading to Iraq.


Also, the clinics here are much more sanitary and better equipped, said Lee. It is possible to conduct surgeries and operations in the field, but it is always safer in garrison. But, if a Marine does need dental assistance in Iraq, he will get treated to the best of the clinic's ability, Lee added. "We don't turn anybody away in Iraq, so it's much easier to be seen, but if possible it's still a better idea to get it taken care of before heading out," said Lee. "Because we don't turn anyone away, the lines are always backed up and everything ends up taking the same amount of time anyhow."

The clinic also sends out a roster to identify Marines who need dental assistance and the dates of their last visits, said Lee. Marines who fall into the Class 3 or 4 categories are considered undeployable in the system until their dentist says otherwise.

Base dental care is broken down into four classes, depending on the last time they were treated and the future treatment they may require.

Class 1 means there is no treatment required. Class 2 means there is minor treatment required, but the patient has 12 months to make an appointment. Class 3 means major treatment is required, and the patient must attend an appointment within 12 months. Class 4 means the patient has not been examined in more than a year.

Overall, making and attending dental appointments prior to deployments are beneficial to everyone involved. It gives the Marine a fresh mouth to deploy with, which provides a healthier Marine to do his job in Iraq and it helps the dental clinic to complete its mission.

A few things to remember and take notice of for those deploying are as follows: Brushing with even a dry toothbrush can and will prevent gingivitis. Flossing after each meal will help prevent cavities and tooth decay. Energy drinks and sodas will quicken the effects of cavities and tooth decay. Wearing mouth guards during physical training will prevent the loss or chipping of teeth. Avoiding cigarettes, cigars, smokeless tobacco, and chaw will prevent the staining of teeth, gum disease, and cancer. 

—Story by CPL Matthew K. Hacker, 2nd Marine Logistics Group, Marine Corps Base, Camp Lejeune, NC.

Lejeune Hospital Unveils New Mother Baby Unit and Exchange Pharmacy

Two ribbon-cutting ceremonies 3 November marked the grand opening of a \$5.5 million renovated Mother Baby Unit at Naval Hospital Camp Lejeune and a full-service pharmacy at the Camp Lejeune Marine Corps Exchange.

The new unit called Coastal Carolina Mother Baby Unit at Marine Corps Base Camp Lejeune consists of 18 new labor and delivery suites. Special features include a level II nursery for newborns that requires close monitoring and treatment from birth to 30 days of age, an infant security system, and lactation consultants.

The joint venture is a result of collaboration between Naval Hospitals Camp Lejeune and Marine Corps Air Station Cherry Point. As a result of the improvement, hospital officials plan to increase the number of monthly deliveries. Additionally, the unit provides 24-hour coverage by a birth team staffed by obstetrics and gynecology (OB-GYN) providers, midwives, and family practice providers.



Congressman Walter B. Jones; MGEN Robert C. Dickerson, Commanding General, Marine Corps Installations East; RADM Donald R. Gintzig; COL Adele E. Hodges; CAPT Eleanor V. Valentin; and CAPT Mark C. Olesen, cut the ribbon opening the Coastal Carolina Mother Baby Unit. Photo by HM3 Rebecca L. Davila, Biomedical Photographer, Naval Hospital Camp Lejeune, NC

“It took us a while to complete the renovation, and as a result of a lot of hard work and dedication,” said CAPT Mark Olesen, commanding officer, Naval Hospital Camp Lejeune. “We are ready to move forward to better serve our patients.”

According to CAPT Eleanor Valentin, commanding officer, Naval Hospital Cherry Point, military family members requiring maternity care who live between Lejeune and Cherry Point can choose to continue using the military healthcare system if they elect to.

The new, larger and more spacious rooms feature state-of-the-art equipment for the baby and mother and offers a comfortable sleeper chair for overnight stays for dads or family members.

Later in the day, the hospital cut the ribbon opening a new, full-service pharmacy at the Camp Lejeune Marine



Jay Sollis, Marine Corps Community Services Assistant Chief of Staff; CAPT Mark C. Olesen; RADM Donald R. Gintzig; COL Adele E. Hodges; Carlton Mencer, Retail Division Director, Marine Corps Community Services; and LCDR Joseph Flott pharmacy department head. Photo by HM3 Rebecca L. Davila, Biomedical Photographer, Naval Hospital Camp Lejeune, NC

Corps Exchange. "Patients can drop off their scripts, and pick up their scripts later," said LCDR Joseph Flott, head of the pharmacy department.

For patients' convenience, the exchange pharmacy offers a phone line that patients can use to reach the Tricare Mail-Order Pharmacy if they desire to order medications by mail and have them sent to their home.

The ceremony was attended by Congressman Walter B. Jones, of North Carolina 3rd Congressional District; RADM Donald R. Gintzig, deputy commander, Task Force Navy Family and Associate Chief Bureau of Medicine and Surgery, Health Care Operations; COL Adele E. Hodges, commanding officer of Marine Corps Base Camp Lejeune; as well as other dignitaries and guests.✍

—*Story by Raymond Applewhite, Naval Hospital Camp Lejeune Public Affairs.*

Expanded Dental Coverage for Children and Other Eligible Beneficiaries

The National Defense Authorization Act of 2007 legislated a change to the TRICARE dental benefit to cover anesthesia services and institutional costs for dental treatment for beneficiaries with developmental, mental, or physical disabilities, and children age 5 or under. For TRICARE to reimburse claims, beneficiaries must save their bills for medical care occurring after 17 October 2006. The change in statute does not include the actual dental care services coverage through the TRICARE Dental Program and the TRICARE Retiree Dental Program.

Once program officers finalize implementation requirements, TRICARE will announce when beneficiaries may submit their bills for reimbursement. Implementation requires changes to TRICARE Manuals and dental care services contracts.

To avoid costly and extensive dental procedures requiring anesthesia, children should start seeing a dentist by the time their first tooth appears or by their first birthday; this helps to prevent tooth decay and other oral diseases. Decay is the single most common chronic childhood dental disease—and it's completely preventable.✍

—*TRICARE Public Affairs, Falls Church, VA.*

Joint DOD/VA Team Assesses NMCS

A joint DOD/Veteran's Affairs review team visited Naval Medical Center San Diego (NMCS) 14 November, to see first hand rehabilitation and transition programs current-

ly in place for returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) recovering combat casualties recovering here.

The visit to Balboa and other area medical facilities is in response to a request from the Undersecretary of Defense for Personnel and Readiness to evaluate administration of injured military members.

In addition to current programs, the four members of the team questioned staff as to what improvements can be made and resources are needed to better aid combat service members. "We want to hear the good and the bad. We are looking at overall policy and laws that aid and impede what our wounded returning need and get it for them," said LCOL Michael Luft, USAF, Inspector General Representative. In addition to Luft, the Inspector General team consisted of COL John Lorentz, USAF, and Stephen Chiusano. Rounding out the delegation was Lin Clegg of the Veterans Administration.

Following a short in-brief with Deputy Commander, NMCS CAPT David Tam, the team took a tour of the hospital's Combat Casualty Comprehensive Care Center (C5). In C5, the team learned that despite the center being a work in progress; approximately 40 patients are currently receiving treatment with room for more. Members of the C5 team expressed the desire to take more patients from Walter Reed Army Medical Center and National Naval Medical Center, Bethesda, especially those whose families live on the West Coast. C5 is an enhancement of the medical care that has been done since the war began. "

For those further along in their rehabilitation, the next stop was to the Balboa Career Transition Center. Led by CAPT Ann Bobeck, the team heard briefs from representatives from the Department of Labor, Veterans Affairs, and the California Employment Development Dept.

The IG/DOD team finished their tour with a look at how recovering Marines and sailors live and spend their time at Balboa with a look at the Liberty Center and a Med Hold barracks room. "It's an eye-opener to see how returning warriors live and where they are treated," said Clegg. "It's better for us to be here and see first hand."

Luft echoed the need for site visits. "Not only is it important to see the facilities, but the pride in those who care for our wounded."✍

—*Story by MC1(SW) Cindy Gill, NMCS Public Affairs.*



CAPT Ann Bobeck, discusses future planning for the Balboa Career Transition Center with Inspector General Representative, LCOL Michael T. Luft.
Photo by MC2(AW) Gregory Mitchell


TRICARE Seeks Input to Improve Autism Benefit

TRICARE will create a plan under the Extended Care Health Option (ECHO) to provide services for military dependent children with autism. The 2007 National Defense Authorization Act calls for this plan to include the following:

1. Education, training, and supervision requirements for individuals providing services to military dependent children with autism;
2. Standards to identify and measure the availability, distribution, and training of individuals (with various levels of expertise) to provide such services; and
3. Procedures to make sure such children receive these services in addition to other publicly-provided services.

TRICARE seeks assistance from affected military families to participate in the plan's development. Any affected military family may e-mail comments to ChildrenWithAutism@tma.osd.mil; TRICARE will accept comments until 31 January 2007.

"It is vital we learn about affected beneficiaries and their personal experiences so TRICARE may better meet their needs," said Army MGEN Elder Granger, deputy director, TRICARE Management Activity. "We look forward to expanding available treatment options and access to care for beneficiaries with autism."

Currently, there are a number of treatments available for children with autism, including Applied Behavioral Analysis (ABA). TRICARE shares the cost of ABA for an active duty family member only if a certified provider administers services. It will not cover non-certified individuals even if a certified ABA provider indirectly supervises the individual. 

—TRICARE Public Affairs, Falls Church, VA.

NMCS D Brings Primary Health Care to East County

Naval Medical Center San Diego celebrated the grand opening of the new \$3.2 million East County Primary Care Clinic in Santee 28 November. It is the first free-standing military clinic in San Diego's East County. Santee began primary care services 13 November.

RDML Brian G. Brannman, Commander, Naval Medical Center San Diego said in his remarks that it had been a short interval from the initial concept to the opening. Ground broke for the clinic 24 February 2005.

"This clinic is a Navy medicine, Navy health care and family effort," said Brannman. He added that there is hope for a long relationship and a bigger, more vital part of the



From left to right are Joe Browning, Senior Congressional Field Liaison to U.S. Representative Duncan Hunter; the Honorable Randy Voepel, Mayor of Santee; RDML B.G. Brannman; Ms. Sarah E. Simpkins, DDS, CHE, Staff Assistant to the Director, VA San Diego Healthcare System; CAPT S.M. Marks, NC, USN, Director for Primary Care; and CAPT David A. Tam. Photo by MC2 Greg Mitchell, USN


Santee community. "The idea of a clinic in East County came from seeing parents of pediatric patients who live in Lakeside drive from 32nd St. [to] home to get their child and return to Balboa for an appointment," said CAPT David A. Tam, deputy commander, Naval Medical Center San Diego, who led the focus group and oversaw the project. "There was definitely a need for quality healthcare in the area, and now we have it."

An unusual aspect of the clinic is the early involvement of patients and family members at the conception of the clinic. Leading the group was Tam and CDR Lisa Ziemke, MSC (Ret.). Other members included seven patients and architect Marcus Thorn.

A focus group was established to use the patient and family centered care philosophy in the planning and delivery of healthcare. Suggestions incorporated into the clinic ranged from exam room layout and warm colors to televisions and a separate child care center.

Another suggestion from the focus group was the implementation of pharmacy pagers. With the clinic located in a shopping center rather than a Naval Base, patients can run errands while waiting for their prescriptions.

Physically, the clinic consists of two buildings. The main building houses primary care, including 10 examination rooms and two treatment rooms, along with the radiology and clinical laboratory spaces taking up 6,500 square feet.

The second building has the pharmacy which features a new state-of-the-art robotic prescription dispensing system. Also, there are the administrative offices, video teleconference room, and staff lounge. 

—Story by MCS1(SW) Cindy Gill, Naval Medical Center San Diego Public Affairs.

Navy Medicine Takes First Step With LASIK for Aviators

Corrective eye surgery has taken a big step into the final frontier of Naval Aviation. For the first time, as part of a new program, the vision correction surgery LASIK has been performed on an aviator. Previously, aviators have been ineligible for this surgery.

According to CAPT Steve Schallhorn, Navy Program Manager for Refractive Surgery, Laser In Situ Keratomileusis, or LASIK, is not currently approved for use in the aviation community. However, a new BUMED project is underway after many years of intense clinical trials on non-aviation personnel. Another milestone of the procedure is wave front guided LASIK (CustomVue) in combination with a femto-second laser (Intralase) to create the flap. This combination represents the “best of the best” according to Schallhorn.

Though this procedure is becoming more common in the community, NMCSD’s Refractive Surgery Center is the only center currently in DOD to offer the combination. This should change soon as the Intralase becomes available to other Navy refractive surgery centers.

In all, Schallhorn completed the 20-minute procedure though the actual laser surgery took approximately 25 seconds. “This procedure on an aviator is a milestone for refractive surgery, both for the military and the community in general,” said Schallhorn.

The first candidate was CAPT Michael Oginsky, USMC, an FA 18/D weapons and sensor officer with VMFAT 101 at Marine Corps Air Station Miramar.

There are four additional aviators scheduled to take part in the first step of the program. Though LASIK has been around for many years, concerns about the harsh aviation environment have prevented its use. Aeromedical professionals have been cautious of employing the procedure on patients who frequently encounter environmental extremes such as high altitude, dry air, wind blast, and “G” forces.

Finding an acceptable candidate for this first group required specific criteria to be met. Medically, the candidate needs a treatable refractive error that is correctable. Militarily, criteria requirements included a Class II naval flight officer who could be put in a “down status” for 30 days without impacting their squadron.

Oginsky’s vision and timing were perfect for the clinical trial. During a pre-operative consultation, Oginsky said any concerns he had had vanished. “The doctors were confident that LASIK and aviation could come together,” said Oginsky. Oginsky, who had the procedure on both eyes, said the difference was apparent immediately. “I was definitely seeing better right away, and within 4 hours my vision was 20/20,” said Oginsky. “At the 24-hour mark, my vision was better than 20/20.”



Dr. Schallhorn performs LASIK refractive surgery on CAPT Oginsky. Photo by LCDR Tyson Brunstetter

According to LCDR Tyson Brunstetter, Research Director one of the biggest concerns that was successfully addressed in a series of NMCSD studies has been the re-adhesion of the flap. At the 1-week follow-up, doctors said the surgical flaps had sealed, reported Oginsky.

The trials are a big step forward in what is a common procedure. Oginsky is already able to see farther out with crisper, clearer vision, and hopes to enter pilot training in the next 2 to 3 months. [↗](#)

—Story by MC1(SW) Cindy Gill, NMCSD Public Affairs.

Blimp Ride for Critically Ill Children of Naval Medical Center

Children from Naval Medical Center, San Diego participated in a blimp ride over San Diego sponsored by SANYO and the Believe in Tomorrow National Children’s Foundation 16 December.

The blimp ride is part of a program that is intended for children with life-threatening illnesses, providing them with “positive, unique experiences,” according to a Believe in Tomorrow press release. “All the cars look like little Matchbox cars from up here,” said Kevin, 13, a Naval Medical Center patient. “I’ve never been this high before in my life!”

The SANYO blimp is one of the largest passenger-carrying blimps in the nation and is used to provide rides for criti-




Children from Naval Medical Center San Diego, soar above southern San Diego in the SANYO blimp, part of the “Believe in Tomorrow’s Hands on Adventures” program for critically ill children. Photo by MC Daniel A. Barker, USN

cally ill children in cities throughout the United States, Mexico, and Canada. SANYO, a corporate sponsor of the Believe in Tomorrow National Children’s Foundation, launched its flagship blimp in July 1997.

“For the kids that we serve, who are dependents of armed service members, it’s just a small way of giving back for everything that everyone in the Navy gives us,” said Brian Morrison, founder and CEO of the non-profit children’s foundation.

Many of the parents on board said the birds-eye view of San Diego was one that most of the pediatric patients would otherwise never have a chance to see.

“It’s going to raise the spirits of all the children who are on board,” said CMM(AW/SW) Michael James, assigned to USS *Peleliu* (LHA-5). “It’s a once in a lifetime opportunity for them, and hopefully it’s going to give them something to believe in.”

The SANYO blimp has given rides to hundreds of children with life-threatening illnesses throughout North America. 

—Story by MC Daniel A. Barker, Fleet Public Affairs Center, Pacific.

Disabled Navy Vet Completes New York City Marathon With Freedom Team

When HN Elmer Dinglasan, USN (Ret.) crossed the New York City Marathon finish line at 2 hours 46 minutes and 22 seconds he was in a hand-crank bicycle loaned to him by the Achilles Track Club. In completing the marathon, his remarkable rehabilitation, which started with walking again after 3 months, continued.



HN Elmer Dinglasan attends his last training session in Central Park before competing in the New York City Marathon the following day. Photo by LT Lesley Lykins, USN

The double amputee lost both legs serving with Marine Expeditionary Unit 22 in the Al Anbar Province last January when an IED went off. After extensive and intensive rehabilitation at Walter Reed Army Medical Center, Dinglasan was walking at 3 months. Completing the 26.2 mile marathon in his specially-made bicycle was yet another major mile-

stone for the 37 year old.

HN Dinglasan and 50 other members of the Achilles Freedom Team, a team established within the club to specifically include wounded veterans, participated in the marathon and finished the grueling race thus reaching another plateau in their rehabilitation.

“For me, it’s feeling normal to be out in public,” said Dinglasan of his first marathon. “I don’t get tired as much and I’m pushing myself. It feeling normal again.”

Dinglasan was cheered on by friends at the sidelines, but they stressed that his training had prepared him well. His training regiment included learning to walk on his new prosthetic legs and doing his regular military PT. His eventual goal is to RUN a marathon.

He joined the Navy after 11 September 2001 to serve his country. His desire was to become a hospital corpsman because he had a degree in medical technology. He said working with the Marines was a great experience for him since he taught them medical skills and they taught him combat skills. Dinglasan credits them with saving his life when he was injured.

The Achilles Track Club is a not-for-profit organization that provides and facilitates distance running and wheelchair athletic opportunities for disabled people. It set up a running program at Walter Reed Army Medical Center in February 2004 for disabled Iraqi war veterans, most of whom are amputees. With support from Achilles coaches and volun-

teers, veterans learn to walk, jog, and run. The organization Freedom team is comprised of severely disabled veterans who compete in the NYC marathon and other running events.

Mary Bryant, who serves as the Director of the Freedom Team, explained that this marathon weekend was about disabled veterans setting goals, especially for the many first-time participants. She hopes that others will look at the examples set by HN Dinglasan and the 50 or so other Freedom Team members and draw strength from them.

"If you are here and still breathing, we focus on the strength that you have. The Freedom Team is made of those that serve or have served our country and have been wounded. They are here actually setting goals and it is exciting," said Bryant.

"Just get out there. There is a lot of support." she advised. ⚓

—Story by LT James McCue, NAVINFO East.

Naval Hospital Bremerton Sees Double

Talk about a duality of purpose. HM2 Lindgren has been a model sailor and exemplary corpsman during her 5 years and 10 months active duty status and 2 years in the Navy Reserves. HM2 Lindgren has also been a model sailor and exemplary corpsman during her 5 years and 10 months active duty status and 2 years in the Navy Reserves.

The previous statements aren't redundant, nor is one a repeat of the other. There is however a double standard, one that can only be applied to twins.

HM2 Jennifer Lindgren and HM2 Jayme Lindgren spent their 2-week active duty service supporting Naval Hospital Bremerton from their home in Helena, MT.

Jayme has been assigned to NHB's inpatient ward, assisting with the care and treatment of pre-operative and post-operative patients. Jennifer has been working in the emergency room conducting procedural work as a nurse's assistant. "We really enjoy working here," said Jayme. "This is our second year in a row coming here. Every day is active and busy. It's such a great learning environment." "We're helping out doing as much as we can," explained Jennifer. "One other corpsman mentioned that they were glad we were there because we knew what we were doing."

"They are very motivated, very dedicated and exceptional in every way," said HMCM(SW/AW) Tom Countryman, Nursing Services Directorate Leading Chief Petty Officer. "Their work ethic is stellar. They might be second class petty officers now, but I see them in khaki in the future."

Working and learning has been a duel road for the duo. During their active duty years, Jayme and Jennifer served at Naval Hospital Lemoore, Naval Hospital Guam, and Naval Medical Center Portsmouth. They will soon start their third



HM2 Jennifer Lindgren and HM2 Jayme Lindgren tidy up in NHB Inpatient ward. Photo by Douglas H. Stutz

year at Montana State University, with a solid emphasis on medical studies.

"The experience we get here at Naval Hospital Bremerton is invaluable," noted Jayme. "The command philosophy is that Reservists and active duty are all one Navy, and that's really true."

As identical twins, although Jennifer will let it be known she was born 2 minutes before her sister, they have gone through the mistaken identity routine in dealing not only with their peers, but patients also.

"We had people confused all the time on Guam, especially the patients" remembered Jennifer. "We would do a turn-over to one another and always get puzzled looks."

Although they both agree that Jennifer is a little more outgoing and Jayme a bit more book-savvy when it comes to schoolwork, there isn't any sibling rivalry. If anything, they compliment each other. "Being twins doesn't impact our work," Jayme said. "If anything, it makes us more comfortable, and it's like having a best friend to work with and live with."

"We were raised as individuals," said Jennifer. "And our mutual experiences have brought us closer together."

The time spent on active duty and in the Navy Reserves has been a nurturing time for both twins. They have shown progressive improvement in advancement on a professional, as well as a personal basis. "We've both definitely grown being in the Navy," stated Jennifer. "Our mom has said that we're both more outgoing and our friends all think that with our experiences as Navy corpsmen, we have a lot better chance in succeeding in our chosen fields than if we just stayed at home and didn't make the effort to learn on our own."

It's not just their friends at home who have been impressed by their professionalism on the job. "They're the future," Countryman noted. "They'll be running the show." Some might call that a twin bill definitely worth catching. ⚓

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



Camp Taqaddum, Iraq. Assistant Division Commander, 1st Marine Division, MGEN Robert B. Neller, right, receives a flu shot from HM2 Gabriela San Martin, attached to the 1st Marine Logistics Group, at the main surgical facility. November 2006. Photo by SGT Alicia J. Brito, USMC



Republic of The Philippines. PFC Hariette Baculi, a medic with the Philippine Army's Light Armor Brigade, watches HM3 Tyber Cheever with the 31st Marine Expeditionary Unit (MEU) takes the vital signs of a student at the Barangay Margulo Elementary School during a community relations visit in Capas, Tarlac. The 31st MEU participates in bilateral training exercises Talon Vision and Amphibious Landing Exercise (PHIBLEX) FY 2007. October 2006. Photo by SSGT Ricardo Morales, USMC



Azuma Island, Japan. Doctors and corpsmen from U.S. Naval Hospital Yokosuka, Japan Special Medical Operation Response Team (SMORT) assist a patient during a mass casualty drill held at the Hakozaki Fuel Terminal on Azuma Island. November 2006. Photo by MC2 Chantel M. Clayton, USN



Kandahar, Afghanistan. HM2 Stephen Thurston, with Marine Helicopter Squadron 365 (Rein.) takes a break during flight operations. September 2006. Photo by CPL Jeffrey A. Cosola, USMC



Arabian Sea. HM3 Brandin Huggett from guided-missile cruiser USS Anzio's (CG-68) rescue and assistance team provides medical aid to a crew member from the motor vessel Al Shams, a Pakistani-flagged dhow. November 2006. Photo by IT1 Christopher Barb, USN



Pacific Ocean. HM2 Noel Toledo applies wax to a mold of a mouth in the dental office aboard USS *Ronald Reagan* (CVN-76). October 2006. Photo by MC Benjamin Brossard, USN



Pacific Ocean. LT Steve Manzoni sutures closed an oral incision while HN Alex Johnson assists. With more than 20 personnel and a full-service clinic, USS *Kitty Hawk's* (CV-63) Dental Department provides services ranging from oral surgery to preventive services to more than 3,000 sailors. November 2006. Photo by MC Stephen W. Rowe, USN



Camp Hansen, Okinawa, Japan. HM1 Leonardo Carbonel (right), a corpsman with Combat Logistics Battalion 31, 31st MEU, tries to communicate with PFC Ryan Ochola, a rifleman with the Battalion Landing Team, 1st Battalion, 5th Marine Regiment. The Marine is a role player during a civil-military operation exercise during MEU Exercise 06-2. Faced with townspeople playing the roles of injured, sick, and crying for medical assistance, the Marines and sailors of CLB-31 rapidly responded. September 2006. Photo by LCPL Kamran Sadaghiani, USMC



Djibouti, Africa. CDR Craig Bonnema, Command Surgeon for Combined Joint Task Force Horn of Africa (CJTF-HOA), checks the heart of a sailor during a routine physical examination at Camp Lemonnier. October 2006. Photo by CMC Eric A. Clement, USN



Charkh, Afghanistan. HMC Rick Wilson, with the Cooperative Medical Assistance team, checks the ear of an Afghan boy during a routine check-up as part of a medical and veterinarian civic action program. October 2006. Photo by SGT Joey L. Suggs, USA

3rd Medical Battalion Prepares for Frontline Readiness

Nearly 200 Marines and sailors with 3rd Medical Battalion (Bn), 3rd Marine Logistics Group, conducted a mass-casualty exercise in the Central Training Area, Okinawa, as part of Exercise Autumn Endeavor 2006. "The main purpose of the exercise is to get the surgical companies and their equipment out in the field," said CDR Marty McCue, the commanding officer of 3rd Medical Bn. We need to make sure the battalion is capable of properly setting up expedient medical facilities in a timely manner to test their abilities in order to support a real-world mission."

Nearly 15 Navy doctors and nurses from U.S. naval hospitals here and in the U.S. joined in the training. "Through the Health Service Augmentation Program, Navy doctors and nurses deployed to Okinawa so they could get experience, and in some cases, more experience using medical tools in the field," said LT Ryan Meskimen, the battalion operations officer.

CDR Joe Taddeo, a general surgeon for U.S. Naval Hospital Yokosuka, who also deployed to Pakistan last year, said the field training is helpful when preparing for deployments. "Especially critical is the time immediately following an injury," he said. "This is what we call the golden hour," Taddeo said. "This is where we make sure the casualties are breathing and not bleeding. When casualties come in, it's a matter of life or death. That's why we need to be near the Marines in any situation."

The battalion relied on its headquarters and service company Marines to supply tools and manpower the sailors need to conduct the exercise, Meskimen said. "Without the Marines, none of this would have happened," he said "They provide us with personnel to help set up the facilities, generators, and communication assets. Without them, we couldn't go to the fight."

The Marines began the exercise conducting military operations in urbanized terrain in Combat Town. When they sustained simulated casualties, Marines were medically evacuated to waiting corpsmen who began life-saving steps.


Casualties arrived with mock wounds simulated with moulage, a type of crude makeup designed to enhance the realism of the training. After the wounded were checked in and initially treated, they were sent to either the Forward Resuscitative Surgery System (FRSS) tent or the Shock Trauma Platoon's tent. "Basically, a FRSS is a surgical room where casualties are brought if they are in immediate danger of losing their life," Meskimen explained. "The STP is where casualties with flesh wounds are sent so they can heal before being sent back out to fight or to the rear to heal longer. Both are mobile and designed to go where the fight is."

If injuries are serious enough, casualties are transported to the Surgical Company in the Combat Service Support Area



Inside a Forward Resuscitative Surgery System (FRSS) tent, CDR Joe Taddeo (left) instructs corpsmen how to treat a casualty. Photo by LCPL Bryan A. Peterson, USMC

for more in-depth care, he added. Depending on the outcome, the injured will stay there or be sent to a fleet hospital.

Twelve Japan Ground Self Defense Force soldiers also attended the training as observers. They came to the training as part of the Japan Observer Exchange Program. "We need to study what could happen in war," said 1st LT Makiko Takahashi, a medical planner with Ambulance Platoon, JGSDF. "We need to know how to rescue patients from the frontlines. The training was well organized and I learned a lot." 

—Story by LCPL Bryan A. Peterson, Marine Corps Base, Camp Butler, Okinawa.

24th MEU Sailors, Marines Celebrate Navy's 231st Birthday

For the last 231 years, the U.S. Navy has patrolled the oceans of the world, maintaining a presence on every strategically important body of water, engaging and defeating the nation's foes at sea, and assisting with logistics and transportation in almost every major offensive ever mounted by the Marine Corps.

Recently at Camp Virginia, Kuwait, the sailors comprising the MEU's medical and chaplain detachments came together at the mess hall to conduct a traditional Navy birthday observation. The ceremony included a formation, reading of letters from the commandant of the Marine Corps and the Secretary of the Navy, and a cake.

HN Cezar Jaramillo, was the youngest sailor present at the ceremony and received the first piece of cake. "Today's ceremony was to celebrate the Navy's birthday to honor the traditions," said Jaramillo. "It's been around for 231 years. This is to pay respect to the Navy."

Some sailors took the day to remember the Navy's long history and to consider how the actions of today's sailors will motivate and guide future generations.



CDR Gary Carr, oldest sailor in attendance, cuts the cake with help from HN Ceazar Jaramillo, during the cake cutting portion of the Navy's 231st birthday ceremony at Camp Virginia, Kuwait.
Photo by CPL Matt Lyman, 24th Marine Expeditionary Unit.

"Sailors today are joining what is literally the best fighting organization the world has ever known," said CDR Gary Carr, a chaplain assigned to the 24th MEU. "The things that sailors are learning and doing will be talked about and remembered for years to come."

"Sailors today should keep hope alive, keep faith and know that the last 231 years have made a lot of sense, and we will continue to do great things for years to come," added Carr.

The enduring success of the U.S. Navy can be attributed to their tireless reinforcement of their core values and the concerted effort they display day in and day out to maintain a high level of professionalism and dedication.

"I'm really proud to put this uniform on and do those men proud who've given the ultimate sacrifice in those battles that they fought before us," said HM3 Brent Booze, assigned to Battalion Landing Team 1st Battalion, 8th Marine Regiment. "Every day I think about those sailors who've made those sacrifices so we can be where we are today."

In his birthday message, the Secretary of the Navy said that in the war on terror, there are more sailors serving ashore in the desert than are serving on ships in the Arabian Gulf.

"I've been involved with 20 Navy birthdays now and they get better and better every year," said HMCS Terry Prince, the senior enlisted leader of 24th MEU sailors. "These are Americans who are taking the fight to the terrorists. Sailors, taking the fight to the terrorists and serving their country," added Prince.

The 24th MEU is composed of its command element, BLT 1st Bn., 8th Marines, MEU Service Support Group 24, and Marine Medium Helicopter Squadron 365 (Reinforced). The 24th MEU is currently conducting training in Kuwait. ✂

—Story by CPL Matt Lyman, 24th MEU, Camp Virginia, Kuwait

Importance of Life Saving Course Stressed in Djibouti

Service members and Department of Defense civilians working at Camp Lemonier went through the Combat Lifesaver Course (CLC), offered by the camp's Expeditionary Medical Facility, in October. "We hope you never have to use any of the things we will be teaching you," said LT Luke McGuffey, NC, course lead facilitator. "But if you find yourself in a place and time where these skills are needed, you'll be very popular."

The course is designed to provide immediate emergency first aid and lifesaving techniques, such as rescue breathing, evaluation of a casualty, heat and cold weather injuries, broken limb splints, and burn treatment. In addition, students of the CLC are taught how to extract a casualty correctly from a danger zone of a battlefield, identify and treat tension pneumothorax, a condition in which the

chest becomes filled with fluid or air, and various techniques to stop hemorrhaging, as well as performing a nine-line medical evacuation.

"Our job is to teach individuals to save lives," McGuffey said. "With Operation Enduring Freedom and Operation Iraqi Freedom, we've learned that if we can stop the bleeding with a tourniquet, it gives the doctors more of a chance to save limbs and lives once the casualties get to them. We were finding out that individuals were dying in transit to the doctors from loss of blood."

"The staff that facilitated Camp Lemonier's Combat Lifesaving Course was great," said Chief Cryptological Technician Administrative Jodi Hanlon, a course student. "A



A service member administers emergency medical care to a "wounded" buddy. Photo by CMC Robert Palomares

group of true professionals, they were able to give sailors, soldiers, airmen and Marines invaluable training, which will be crucial in helping save our comrades-in-arms' lives while on the battlefield."

Most of the preventable deaths on the

battlefield are the result of bleeding from wounds to arms and legs.

“Anything that we can do to help prevent those deaths is well worth our time and effort,” she said. “I really have a new appreciation for those medics on the battlefield and those personnel in the medical profession.”

“The combat life saver is the primary link in the military chain of survival between basic first aid and the platoon medic, who is a fully qualified medical professional,” said LT Stephen Guidry, NC.

“Every minute counts, and if these guys can recognize and stabilize wounds quickly, the chance the casualty will live is very high,” McGuffey.✍

—*Story by MCC(DV) Robert Palomares, USN, Camp Lemonier, Djibouti.*

Medical Exercise Helps CNE-C6F Strengthen Ties With Ghana

The medical training exercise MEDFLAG 06, designed to exercise the host nations’ disaster response programs and plans, concluded its portion in Ghana in early October.

This Joint Chiefs of Staff-directed exercise greatly enhanced CNE-C6F’s Theater Security Cooperation (TSC) initiatives in the West Africa Gulf of Guinea region that included other MEDFLAG 06 participant nations—Benin, Nigeria, and Senegal. “Our Health Service Support (HSS) staff has been working with the government of Ghana to help them enhance their navy’s and armed forces’ medical capabilities to improve their ability to manage their coastal security,” said CNE-C6F Force Surgeon CAPT Alton Stocks. “This ties in with the commander’s strategic priority of strengthening our emerging partnerships with West African countries.”

In Ghana, MEDFLAG 06 had two phases, in September and October, said CNE-C6F HSS participant LCDR Pruden, with the activities in the final month targeted toward TSC. “Our focus is maritime safety and security, and that requires host nation personnel being able to respond to incidents on their vessels if they are out at sea,” Pruden explained. “If we can prepare them with technical advice and help them decide what equipment they need, and how to prepare their personnel—both their medical experts and regular crew members—that will help them sustain themselves at sea.”

Pruden was in Ghana to observe shipboard medical familiarization procedures on board USS *Elrod* (FFG-55).

During this medical training aboard the frigate, while docked at Tema Naval Base, an Afloat Training Group Mobile Training Team (ATG MTT) worked with 28 Ghanaian military auxiliary nurses. “I felt very good about the visit,” Pruden recalled. “The students were very receptive, very



A sailor assigned to the guided missile frigate USS *Elrod* (FFG-55), (right) works with Ghanaian army auxiliary nurses on personnel casualty transport techniques aboard the ship. Official U.S. Navy photo

eager to learn, and they jumped right in and participated in drills orchestrated by the ATG MTT.

“Additionally, the ATG MTT personnel assessed from their interaction with and observation of the Ghanaian Armed Forces personnel that the topics were quite appropriate to their level of competency.”

Also during this 6-day visit, Pruden had the opportunity to visit medical facilities in Tema and the nation’s capital Accra, where he was able to learn firsthand about Ghana’s state of medical readiness. “They take healthcare very seriously, especially in the military,” he noted. “The 37th Military Hospital in Accra is a national triage facility and is becoming the premier facility in Ghana treating both military and civilians. The facility also serves as a teaching hospital for interns, residents, nurses, and orderlies (auxiliary nurses). Their preventive medicine program is very well developed and, in fact, is run by their senior Navy physician. However, Ghanaian Armed Forces medical leaders have identified operational navy medicine as an area they desire CNE-C6F cooperation to improve.”

Stocks and Pruden agreed that the ease in working with the Ghanaians—due to the lack of a language barrier, as well as the country’s relatively advanced technology—make the lessons learned from MEDFLAG 06 there into an ideal template for sharing knowledge with other nations.

“Our intent is to use this as a model to help other countries build their armed forces medical communities throughout the rest of Africa,” Stocks elaborated.

“The thinking is that if we can be successful in Ghana, because the process is easier up-front, then we will have a much better developed program to offer other countries as we engage with them,” Pruden added.✍

—*Story by MC1(SW) Eric Brown, NAPLES, Italy.*

Corpsmen Save Young Iraqi Girl's Life

The 9-year-old Iraqi girl would have died without their help. Riyam Shihan's cousin was trying to close a heavy, metal door, at a home in Habbaniyah when it became unhinged and fell on Riyam, crushing her skull in late November. The bone was fractured and she was bleeding profusely. With each passing minute, rapidly building pressure within her brain was causing more damage.

When she arrived at Camp Taqaddum (TQ) Surgical, her condition deteriorated quickly. Fearing the worst, doctors and corpsmen "launched into action," said LCDR Pamela C. Harvey, a doctor with TQ Surgical, 1st Marine Logistics Group (Forward).

They medicated her intravenously and inserted a breathing tube. But because of the injury to her brain, she had lost the ability to clot blood. Surgeons sent out a 'walk-in' blood bank message. TQ responded immediately with almost two dozen donors. With more blood, Riyam was able to stabilize, but because they lacked a specialized neurosurgeon in TQ, surgeons were forced to send her to a different hospital. In the early hours of 14 October, an unconscious Riyam Shihan was flown to a higher level hospital. TQ Surgical's staff doubted she would survive the required surgery, much less walk and talk again. So when Riyam walked back into the hospital a month later and asked for strawberry bubble gum, surgeons and corpsmen were amazed. "Back in the states, with an injury like this, the patient would be operated on in 45 minutes," said CDR Theodore D. Edson, TQ surgeon. Because bad weather had been blocking flights out of Taqaddum the night of her injury, Riyam hadn't gotten her operation until almost 6 hours after the injury took place.

"That girl must be someone really special," said Edson.



CDR Susan P. McKeefrey, NC, and LCDR Pamela C. Harvey, MC, with TQ Surgical got to see Riyam Shihan again during an arranged meeting in Habbaniyah. Photo by LCPL Geoffrey P. Ingersoll, USMC

Coalition forces found out later that she is a very special girl. She is the granddaughter of a sheik, or tribal leader, in Habbaniyah. "The Iraqi people of Habbaniyah hear what the coalition forces have done to save my granddaughter, and they cry. They are very grateful and you have gained them to your side," said Riyam's grandfather, Aved Shihan Ghathaib.

Since the girl was saved, a ripple effect has taken place, and the Iraqi citizens of Habbaniyah have become increasingly supportive of Coalition forces in the area.

But Riyam's fight for life is far from over. Within the next 6 months, she will need a follow up operation to replace the missing piece of her skull. It is a delicate operation that, due to the rebuilding of Iraq's infrastructure, will be almost impossible to provide in her home nation.

The efforts of coalition forces have bought her more time, but without this operation, Riyam's future still remains stormy. ⚡

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

Okinawa Corpsmen Put to Battle Skills Test

Team Dukes of Hansen from 3rd Medical Battalion, 3rd Marine Logistics Group, dominated the 14th annual Navy Battle Skills Competition on Camp Hansen racking up the most points in every event.

The Dukes of Hansen and five other teams of corpsmen from Okinawa units competed in the 4-day event, which is designed to test the knowledge, general field and first aid skills, physical fitness, teamwork, and decision-making abilities of sailors assigned to or in support of III Marine Expeditionary Force.

"In order for the Marines to trust the sailors attached to them, they must know combat skills," said MCPO Yen Duberek, the III MEF command master chief petty officer. "They must be able to hang with the Marines and do their job at the same time."

The competition consisted of seven events: an obstacle course, combined skills course, Zodiac boat race, pistol marksmanship course, forced march, land navigation course, and written exam.

"It's all about teamwork," said Dukes of Hansen's HN Eric D. Stuart, with 3rd Medical Bn. "We didn't necessarily have the goal of winning the competition, but we practiced for a month to see how well we would work together."

Dukes of Hansen's focus on teamwork was visible from the start as they were the only team with every member flaunting a unique symbol of unity—their moustaches.

More than 40 sailors with their respective six teams began the competition with the obstacle course on Marine Corps Air Station Futenma. "Once we came to the rope, it got a



Sailors tend to a simulated casualty at Marine Corps Air Station Futenma during the combined skills course. Photo by LCPL Bryan A. Peterson, Marine Corps Base, Camp Butler Okinawa

little discouraging,” said Combat Care-bears team member HM1 Mishelle Vasquez, with U.S. Naval Hospital Okinawa. “But beyond that, we could accomplish everything as a team.”

The combined skills course followed, designed to test several skills: assembly and disassembly of the M-16A2 service rifle and M9 pistol; patient assessment and treatment; PRC-119 single-channel, ground and airborne radio system assembly; and nuclear, biological, and chemical gear handling.

The next day, the competition moved to Camp Hansen to conduct land navigation and boat races in the Central Training Area. The land navigation course consisted of four predetermined points and the race consisted of assembling a combat rubber reconnaissance craft, also known as a Zodiac, and paddling it 1 kilometer.

“The boat race just drained us,” Stuart said. “But with a team effort, we were able to make good time.” The final 2 days consisted of pistol marksmanship, a written exam, and a 12-mile forced march.

The 3rd MLG North Dukes of Hansen took first place with 590 points. Third MLG South took second place with 530 points and the 3rd MLG 9th ESB, Magic Sticks, took third with 460 points.

For Vasquez and her team, it was about getting out of the hospital and doing the things sailors attached with the Marines do. “Although there was stiff competition, we wanted to get out and challenge ourselves,” she said. “I think we really worked together as a team. I can say with being in the Navy for 12 years, this is by far the best team I have ever worked with for any competition.”

—Story by LCPL Bryan A. Peterson, Marine Corps Base, Camp Butler, Okinawa.

Surgical Company Saves Lives at Al Asad

For the sailors and Marines with Charlie Surgical Company at Al Asad, Iraq, their main concern and focus of their job is to provide the best medical care to the men and women who have met with ill fortune on the battlefield.

“Our main mission here at Al Asad Surgical is to provide level-two care for all patients who are brought to us,” said CDR Richard P. Sharpe, Chief of Professional Services officer-in-charge, Charlie Surgical Company, Combat Logistics Regiment 15, 1st Marine Logistics Group (Forward). “Level-two care involves any seriously injured or ill patient and their surgical management, stabilization, and medical evacuation.”

“About two or three times per week, we will have many very sick or injured patients arrive at once,” Sharpe continued. “Since it occurs so frequently, it’s actually a routine for us now, but it still presents a situation that is very hectic. It requires that everyone not only remains organized, but stays focused and does their job, as well.”

“It’s always, in those instances, a team effort that makes it a success,” added Sharpe. “There can never be just one nurse, one corpsman, or one physician doing their job. It has to be the entire team doing their job right the first time in order to save someone’s life.”

Although the entire hospital is pushed into overdrive when just one patient arrives at its back door, there are the extreme occasions where the men and women working behind the curtains are held in the rush of adrenaline for hours on end.

“We had 24 patients show up in one hour in early October,” said LCDR Gerard J. Woelkers, executive officer, Charlie Surgical Company. “We were able to take care of them, but not only that, we were also able to effectively utilize more than 160 military professionals, 80 of which belonged to this company and 80 who came from all around Al Asad.”

“The folks here are as good as I’ve seen,” Woelkers added. “I’ve been in Navy medicine for 23 years and am really proud to be leading these troops here. I’ve never seen it better. This group not only works well together, but they play well together, too. They put personal agendas aside and save lives.”

As a team, the sailors and Marines of Charlie Surgical Company are considered one of the best, according to HM2 Chris D. Henderson, with Shock Trauma Platoon, Charlie Surgical Company. “We are the best at what we do. Everyone came from different places and different units, and we all gelled together,” said Henderson. “I think it’s the people that make this hospital run as well as it does.”

For some, the fact that they are in Iraq using the profession they’ve trained for, while saving lives, is an honor. Hav-



Marines and sailors rush to get multiple casualties arriving at the hospital into the Shock Trauma Platoon area for immediate resuscitation at Al Asad, Iraq. Photo courtesy of Charlie Surgical Company

ing a slogan that names them the “Cheaters of Death,” the Marines and sailors with Charlie Surgical Company, Combat Logistics Regiment 15, 1st Marine Logistics Group (Forward), strive to do just that everyday, as it is their routine job to save people’s lives.

“It’s a privilege to be here and to be able to see the good things we do,” said LT Aleca M Gende, enroute care nurse, Charlie Surgical Company. “It’s a privilege to work with Iraqi civilians who maybe would not have gotten the quality of care had we not been here.”

—Story by CPL James B. Hoke, 3rd Marine Aircraft Wing.

Deployed “Docs” Keep Skills Sharp

There’s zero room for errors when there’s one “doc,” 18 Marines, and just 60 seconds to save lives. “Docs” here are training to make every second in that one short minute a lifesaving moment.

Corpsmen attached to Weapons Company, 3rd Battalion, 2nd Marine Regiment are keeping their medical skills sharp while multiplying their numbers by continuing their training in a combat zone. They are on duty in Habbaniyah, Iraq, with Regimental Combat Team 5. “Just how Marines have to constantly shoot to be on-point, we have to practice our skills to be on point,” said HN Samuel L. Blanco, with Weapons Company. He points out that says when skills aren’t sharpened, lives are at risk. “In the rear, you could have one doc that’s good at one thing and another that’s good at another thing but out here you have to be good at everything,” said HN Michael J. Harty.

Corpsmen constantly conduct training on applying pressure dressings, tourniquets and intravenous fluids, or needle sticks to push saline solutions—everything needed to treat casualties in a combat situation. Marines serving with docs know their mission is tough and are glad the corpsmen train to help their Marines and themselves. “It’s delightful

that our docs are constantly training,” said LCPL Aaron S. Missey, a mortar man with Weapons Company. “The doc is the only person you’ve got when the worst-case scenario hits,” said Missey.

Harty said the training couldn’t have come at a better time. “Last night, we had a Marine who had bronchitis and the heat got to him,” he said. “We had to cool him off, get him fluids through an IV.” Harty said they cooled the ailing Marine with ice packs until he could be transported to the battalion’s aid station.

“It might have been worse if the ‘docs’ weren’t ready at the drop of a dime. Still, it’s not just the corpsmen who were ready with the jab of a needle.”

Missey said you can’t always depend on the corpsmen because one of them may become a casualty. “It’s not just the doc’s responsibility,” he said. “It’s each and every individual Marines’ responsibility also.”

Marines enrolled in classes like the Combat Lifesaver’s Course need to take the material seriously. Situations in Iraq can turn deadly, quickly. It’s the fast-thinking combat lifesaver and corpsmen who make the difference, Missey said. “When you’ve got less than 60 seconds to fix someone’s leg that’s been blown off—before they bleed to death—you’ve got to keep your head on straight so you don’t lose your friend,” he added.

These docs know this, so they multiply their numbers. Not only did corpsmen train each other, they also trained their Marines in medical skills. Corpsmen taught Marines how to treat casualties until they can receive further treatment when help arrives. “Our confidence in our guys is pretty high,” Harty said. “I know if I go down, the Marines are confident enough to save a life, either mine or another Marine’s.”

This also keeps Marines’ minds focused toward the fight. “With only 1 corpsman in the section, that’s 1 corpsman to every 18 Marines,” Harty said. “Training our Marines becomes really important.”

—Story by LCPL Ray Lewis, 1st Marine Division, Observation Post Falcon, Iraq.



HN Samuel L. Blanco squeezes more intravenous fluids into HN Michael J. Harty, a fellow corpsman. Photo by LCPL Ray Lewis, Combat Correspondent, Regimental Combat Team 5

Combat Promotion Awarded to Hospital Corpsman

Eight months serving as “doc” to the Marines in Iraq has earned HM2 Otis F. Seamon at Naval Medical Center Portsmouth (NMCP) a rare combat promotion.

Seamon served with the Marine Corps ground forces Lima Company, 3rd Battalion, 8th Marines as the Senior Line Corpsman from January to August 2005. While he was officially promoted today to hospital corpsman second class, the promotion is retroactive to September 2006, and is awarded specifically for his outstanding support of his Marine unit in Fallujah, Iraq.

He is cited as providing “superb medical care to his unit while routinely under attack from mortar fire, improvised explosive device (IED) explosions, and suicide vehicle-borne improvised explosive devices (SVBIED). Seamon successfully and single-handedly treated 8 urgent and 20 routine casualties after an SVBIED attack during an on-the-spot vehicle checkpoint and expertly treated nine routine and three urgent casualties after an IED ambush. Seamon consistently treated his Marines and fellow corpsmen without regard for his own safety while maintaining tactical integrity.”

CAPT Bruce L. Gillingham, NMCP deputy commander, promoted Seamon and said, “I am in awe of your accomplishments. There is no higher honor than to be recognized for promotion by the Marine Corps. There is no higher calling for a Navy corpsman than to be up front with his Marine brothers and sisters.”

Seamon is the first sailor from NMCP to advance through the Combat Meritorious Advancement Program since its inception in April 2005. The program provides commanders the opportunity to advance junior enlisted sailors who display uncommon valor and extraordinary leadership while engaged in, or in direct support of, combat operations. With the concurrence of the Commanding General of the 1st Marine Expeditionary Force, NMCP Commander RADM Thomas R. Cullison nominated Seamon for advancement. He was one of only two sailors awarded a combat meritorious promotion to E-5 in this quarter.

Following the ceremony, Seamon was humble, stating “I was just doing my job.” He spoke with pride about service members still deployed, “They’re sacrificing their lives for the people of Iraq.”

He received several awards while deployed with Lima Company: the Fleet Marine Force (FMF) pin, the Combat



Action Ribbon, the Iraq Campaign Medal and the Global War on Terrorism Service (GWOTS) Medal.

Seamon currently serves in NMCP’s Command Education & Training Department teaching the Emergency Medical Technician course. He uses his combat experience to teach Combat Casualty Care to corpsmen who are scheduled to deploy to do just what he did—augment the Marines in Iraq.

And Seamon’s thinking about his future in the Navy. “I plan to go on to officer school and give back more to the Navy,” he said. ⚓

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

HN Christopher A. Anderson, 24, of Longmont, CO, died 4 December 2006 as a result of enemy action in Al Anbar Province, Iraq. Anderson was assigned to 1st Battalion, 6th Marines, 2nd Marine Division, Fleet Marine Force, Atlantic, based in Camp Lejeune, NC.



Society for the History of Navy Medicine Inaugural Meeting Schedule

The historical first official meeting of the SHNM will take place at 1800 on the evening of 3 May 2007 (first day of the American Association for the History of Medicine Conference) at Le Mas des Oliviers in Montreal, Canada.

The tentative schedule of this meeting is as follows:

- 1800:** Dinner and Discussion
Keynote Address by Jan K. Herman, Historian of the Navy Medical Department
- 1930:** Paper Session/Question and Answer Session
 - French Navy, the Societe Royale and Tetanus Research in the 18th Century
 - Navy Medical Artifacts at the AFIP
 - Combat Fatigue from Civil War to Desert Storm
 - Psychiatric Care in the Early Navy.
- 2100:** Discussion

If you would like to sign up or if you would like additional information about this event, please contact CAPT Thomas Snyder, MC, USNR (Ret) at: thomaslsnyder@gmail.com or write to: 131 el Camino Real, Vallejo, CA 94590-3464.

Bolstering the Fighting Strength

CDR Kenneth M. Lankin, MC, USN

COL Tim Mallon, MC, USA

CDR Francesca Litow, MC, USN

CAPT Neal Naito, MC, USN

What does managing worker's compensation cases have to do with Navy medicine and readiness?

Did you know?

The Department of the Navy (DON) spends nearly \$250 million per year on workers compensation claims. The majority of these medically based claims are not reviewed by a Navy medical officer for work relatedness or appropriateness of care.

A single claim for lower back strain can yield over \$1 million in lifetime benefits. Federal employees who work for the Navy are compensated via the Department of Labor's (DOL) Federal Employees' Compensation Act (FECA). Initial payment to the worker is made through the DOL, but the Navy and specific commands are "charged-back" for those costs.

When bases close, the Navy is still responsible for lifetime workers compensation costs related to the federal workers who have accepted claims or who file claims in the future. This procedure results in a large worker's compensation "tail" (claims from former workers) that still needs to be actively managed in order to control costs.

Reductions in force, base closures, and BRAC have been associated with higher workers compensation claims. Workers' comp claims may increase as much as 50 percent during layoffs or business restructuring.⁽¹⁾

Economic strength is necessary to maintain military strength.

Consider Robert Morris, "Financier of the American Revolution" who, in December 1776, managed to borrow \$10,000 to pay Washington's troops. This helped keep the Army together just before the battles of Trenton and Princeton.

Morris sold one of his commercial ships, the *Black Prince*, to the Continental Congress. It later became the *Alfred*, the first ship in the Continental Navy. A captain who sailed for Morris' company became the Captain of the *Alfred*. He was John Barry, later Commodore John Barry. If it weren't for the financial contributions of Robert Morris, would the Americans have won the battle for independence?

Now, growing financial demands challenge the Navy's ability to carry out its mission.

The Navy pays approximately \$250 million annually in workers' compensation and related medical benefits under the FECA program. This workers compensation bill is the highest among current Federal agencies.⁽²⁾ The total annual DOD expenditure on workers compensation is over \$600 million dollars a year. Even a very modest 10 percent reduction would free an extra \$25 million each year the Navy could spend on personnel or military hardware.

What is Worker's Compensation?

Worker's compensation is an economic stabilization system. Worker's forfeit the right to sue their employers in exchange for covered benefits if killed, injured, or made ill because of a work situation. Employers agree to pay benefits, without necessarily being found "at fault." In theory, workers and employers are better off by avoiding costly court battles.

Worker's compensation may also be viewed as a type of social insurance, just like Social Security. The modern concept of worker's compensation has its roots in the Industrial Revolution. Industrialization swept through Europe creating great wealth but at the same time new classes of working poor, and a plethora of horrific injuries that had not been previously witnessed.

Under English Common Law, the injured worker had only one recourse: to sue the employer. It was virtually the same system that existed in Germany. Germany took the lead internationally in the protection of injured workers in 1838 by passing legislation protecting railroad employees and passengers in the event of accidents. Further changes were made in 1854 when a law was passed requiring certain classes of employers to contribute to sickness funds in the 1876 "Voluntary Insurance Act." Chancellor Bismarck introduced a compulsory plan in 1881, which was finalized in 1884 and is the model for our present system.

Industrialization in the United States grew after the Civil War. The plight of the injured worker drew attention through the garment industry. These "sweatshops" paid very little yet demanded high production, and became the target for the earliest litigation on behalf of injured workers who received nothing if they were injured on the job.

Through the 1880s to the turn of the century, the legal profession in the United States was also growing, and increasing lawsuits had the same effect on the judicial system in the United States that it had in England and Germany—crowded dockets, few judges to handle the cases, and judgments increasingly rendered in favor of the worker.⁽³⁾ By 1908, workers were winning in nearly 15 percent of all cases. The American concept of "workmen's" compensation was now based on that of Germany and England's philosophy: that industry is responsible for the costs of injuries inherent in industrial occupations.

In 1908, President Theodore Roosevelt signed legislation to provide workers compensation for certain Federal employees in unusually hazardous jobs. The scope of the law was very restrictive and its benefits were limited. However, it was the first workers' compensation law to pass the test of constitutionality applied by the U. S. Supreme Court.⁽⁴⁾

Roosevelt thought it was an outrage that "the burden of an accident fell upon the helpless man, his wife and children." The Federal government took the lead in providing workers with protection in the event of on the job injuries in the United States.

In 1911, Wisconsin was the first state to adopt a "workmen's" compensation law. It became the model for other state laws and subsequent Federal law. The salient feature was the "exclusive remedy." Employers agreed to provide medical and indemnity (wage replacement) benefits and the injured employee agreed to give up his/her right to sue the employer. The Federal Employees Compensation Act (FECA) which superseded the 1908 statute in 1916 is a workers' compensation law that provides for wage loss compensation, medical care, and survivors' benefits for all civilian Federal employees.

Like many social programs created to balance injustices, legitimate unforeseen costs have arisen and abuse of the system occurs. Although the Federal workforce is transitioning from industrial-oriented to more "white-collar," workers' compensation costs remain high. Common claims among white collar workers include repetitive use syndrome (e.g. carpal tunnel syndrome), lower back pain, sick building syndrome, and chronic fatigue. Because white-collar "knowledge-based" workers are often higher paid than blue-collar workers, associated workers compensation claims tend to be higher.

The cost of medical care is rising more sharply than inflation and other costs. Sometimes workers are subjected to inappropriate treatments that increase the cost of a medical claim. Rare but costly are cases where frank malingering for secondary gain occurs: a classic situation of someone who is receiving full disability benefits for severe debilitating back pain is videotaped hoisting engine blocks or playing golf.

In a claim the worker must present medical evidence from a physician of his or her choosing as to the work relatedness of their injury or illness. The overwhelming majority of physician opinions submitted by workers supports the worker's perspective and is not evidence based. If there is no evidence based medical opinion from the federal agency as to the merits of the claim, it is not difficult to see why the DOL claims reviewer would rule in favor of the claimant even if the claim is unsubstantiated or fraudulent. Claims reviewers for the DOL do not generally have a medical background.

Medical review of such claims can improve the fairness of the system and result in significant cost savings. A physician involved makes sense as the medical diagnosis and its work relatedness is the core of the review process. Workers can be spared lengthy and costly treatments when early review identifies a problem and a more reasonable medical course of action can be recommended. In cases where malingering is highly suspected, a physician review can assist the Navy FECA office to "controvert" (overturn) unsubstantiated claims. Cost savings can also be enhanced by ensuring appropriate claims are acted upon in a timely manner returning the injured or ill worker back their job as quickly as possible.

Safety, Health and Return-to-Employment (SHARE) Initiative

On 9 January 2004, President Bush announced the Safety, Health and Return-to-Employment (SHARE) Initiative directing Federal agencies to establish goals and track performance in four major areas: 1) lowering workplace injury and illness case rates 2) lowering lost-time injury and illness case rates 3) timely reporting of injuries and illnesses and 4) reducing lost days resulting from work injuries and illnesses. Department of Navy (DON) is among the myriad of Federal agencies tracked by the DOL for this initiative. Occupational health personnel can improve the Navy's performance in all areas of SHARE, especially regarding cost and lost work-time as early "return to work" programs are a key feature of what occupational health provides to commands.

Fundamental Plan: DOD Instruction 1400.25m, Subchapter 810

The most successful programs to curb workers compensation costs at the activity level use case management and a team approach as outlined in DOD Instruction 1400.25M. This program involves workers, supervisors, industrial hygienists, safety managers, human resource personnel, occupational health nurses, occupational medicine physicians, and the base commander. The support of the installation commander is vital for the program to have the necessary resources and visibility to succeed. This support manifests itself in the availability of light duty positions or accommodations to transition ill or injured workers during recovery before being returned to full duty.

Of note, 1400.25M requires activity level medical officers to review all cases of reported occupational illness and to take or recommend action. Upon the request of the activity workers compensation program administrator (in the instruction identified as the ICPA or Injury Compensation Program Administrator), they are also required to

provide medical information to be sent to the Office of Worker's Compensation Programs to support or controvert a claim for an occupational illness or work related injury. Furthermore, activity medical officers are directed to conduct reviews of medically complex or controversial cases.

Medical Management Optimization

One resource that is vastly under utilized is the use of a military occupational medicine physician in reviewing all claims of work related injury or illness. While occupational medicine is among the smallest of medical specialties, it is the discipline that is most closely associated and familiar in evaluating workers compensation issues. A chief question for any claim is determining the "work-relatedness;" a familiar topic to occupational medicine physicians. Military activities that have access to a military physician who can provide an evidenced-based opinion on workers compensation claims operate at a substantial advantage.

"One Navy" Workers Compensation Medical Case Review Program Proposal

Among the Surgeon General's priorities is "One Navy Medicine-Active, Reserve and Civilian."⁽⁵⁾ The "Workers Compensation Medical Case Review Program Proposal" is in line with that goal. It offers enormous opportunities for reservists looking for flexibility in meeting their work time requirements while at the same time making a potentially multimillion dollar contribution to the war effort with a weekend's worth of work. Such a program can make a difference in cost avoidance and preserving the fighting strength.

Implement a process where all Navy Federal workers compensation claims are reviewed by a Navy physician (active duty or reserve) to the work relatedness of the injury or illness, the ability of the claimant to return to work, and the appropriateness of care.

Form a cadre of medical reviewers initially among active duty occupational medicine physicians and residents. Re-

cruit, train, and involve reserve physicians in the program. Reservists represent a large, untapped pool of expertise. Reserve reviewers can be from any field with some additional training. Their initial focus would be on cases that involve an injury or illness related to their specialty field of expertise. Occupational medicine specialists are especially well-prepared since workers compensation is an integral portion of their training.

Create instructional and informational modules on a website with remote access from which any Navy physician can complete training to be a workers compensation medical case reviewer or consultant.

Track quality/productivity metrics including the number of cases reviewed, types of cases reviewed, time spent reviewing cases, outcome of cases, and cost avoidance.

One of the great inefficiencies of the Federal Workers Compensation system is the lack of workers compensation claims review by an agency physician. The value of converting cases and avoiding the costs from inappropriate claims versus the cost of a physician's time, weighs in favor of having of a physician review.

For reserve physicians in voluntary training units (who do not get paid but earn retirement points), performing reviews online could be appealing. If a remote secure website could be established: a) there would be no travel involved; b) it would allow for a flexible work schedule and; c) a valuable and tangible service could be performed conceivably from home. Cost savings can be funneled to improve readiness.

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Ironclad Fever, Flying Boltheads, and Shattered Constitutions

Sandra Moss M.D., M.A.

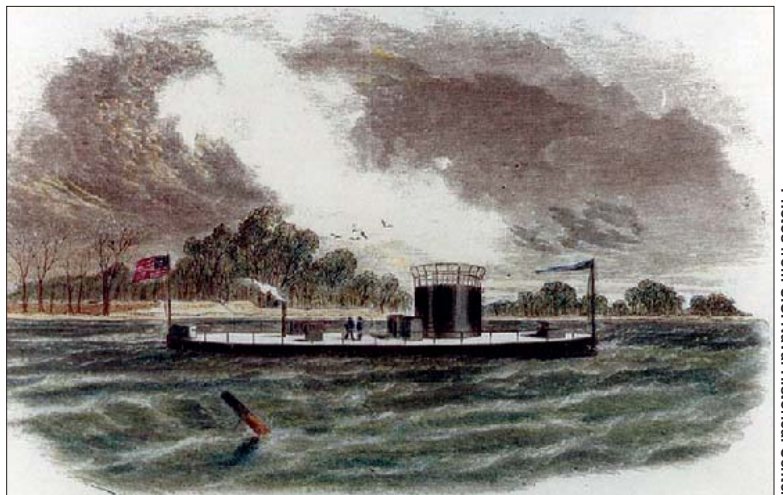
In 1865, the Department of the Navy concluded that Civil War ironclads were healthy vessels. But the officers, men, and surgeons of the monitor-class warships viewed them as dangerously unhealthy. Despite its protective armor, the machine itself seemed to threaten the lives and constitutions of those aboard. Following the epic battle between USS *Monitor* and CSS *Virginia* (ex-USS *Merri-mack*) on 9 March 1862, the Navy hurriedly commissioned 9 Passaic-class monitors similar in design to *Monitor*. Eight saw duty in the Atlantic blockading squadron.

Monitor: “An Iron Coffin-like Ship”

Monitor was 172 x 41.5 x 10.5 feet with a complement of 49; crew spaces, stores, galley, and engine room were below the iron deck, with its signature rotating turret. Light filtered in through 6-inch skylights covered with thick glass and often awash. Ventilation below decks relied on forced air blowers in the engine room. A system of ducts guided the often fetid air into officer and crew quarters.(1)

John Worden, first captain of *Monitor*, described his vessel as “an iron coffin-like ship of which the gloomiest predictions were made, her crew shut out from sunlight and the air above the sea, depending on entirely artificial means to supply the air we breathe. A failure of the machinery... would be almost certain death to her men.”(2) Worden was right. The machinery failed as the newly-commissioned *Monitor* raced

from the Brooklyn Navy Yard to meet *Virginia* at Hampton Roads. Rough seas drove torrents of cold seawater through the intake ports which directed air (and now seawater) onto belts that drove the blowers. When the engines failed, steam, smoke, and “carbonic acid gas” filled the engine room and spilled out into the crew quarters. Engineers, firemen, and coal heavers “were dragged out more dead than alive,” carried to the top of the turret, and placed under the care of the ship’s surgeon.(3) Vessel and crew recovered sufficiently to make the famous rendezvous at Hampton Roads.



USS *Monitor* (1862). Engraving published in *Harper’s Weekly*, 22 March 1862. This copy has been hand-colored.

Photos from U.S. Naval Historical Center

James River Flotilla: “Constitutions So Shattered”

During the spring and summer of 1862, *Monitor*, under the command of William Jeffers, joined the James River Flotilla in support of the Peninsular campaign. Paymaster William Keeler wrote to his wife as shore batteries pummeled *Monitor*: “No one on board was hurt but all suffered terribly for the want of fresh air.... At times we were filled with powder smoke below threatening suffocation to us all. Some of the hardiest looking men dropped fainting at the guns.” Later, he lamented: “Yesterday was a hot uncomfortable day & we lay broiling in our iron box, or cage as it has now become....”(4) CAPT Jeffers informed the naval command “If the hatches were all closed (as they must be at sea) in this warm weather the crew would be unable to live for forty-eight hours shut up. Quite one-third of the crew are now suffering from debility....”(5)

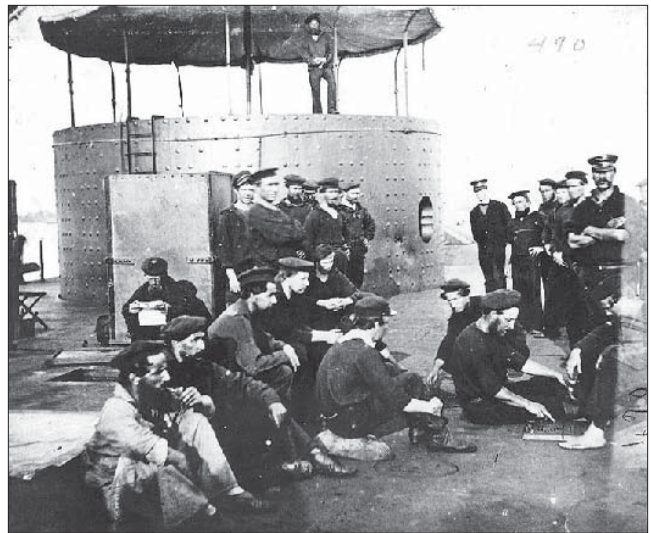
Following the sinking of *Monitor* in stormy seas off Cape Hatteras in the early hours of 31 December 1862, the privately published *Army and Navy Journal* carried a series of letters debating the health risks of the monitors. One pseudonymous letter charged: “If [the officers and crew] escape untouched in life and limb, it is at the expense often of constitutions so shattered that they must bear through years of ill health and suffering the pain otherwise concentrated into a brief period of agony.” Of course, the author, possibly a former *Monitor* officer, could not have predicted “years of ill health” from the vantage point of August, 1863.(6)

Passaic Class Monitors: “Peculiar Hardships and Exposures”

The Passaic-class monitors, successors to *Monitor*, were slightly larger (200 x 46 x 12 feet, complement 75), with improved ventilation systems. According to the medical log, now in the National Archives, Acting Assistant Surgeon Edgar Holden of the Passaic justified the transfer of an engineer with “typhoid remittent fever” to a hospital ship because the “fires are out and the damp and cold are almost unbearable.”(7) The experience on other Passaic-class monitors was much the same. Surgeons completed forms called “hospital tickets” when transferring a sick or wounded crewman to a shore facility or hospital ship. “Adynamia,” exhaustion, and debility were common diagnoses. Monitor surgeons often added annotations such as “owing to the peculiar hardships and exposures men are subject to in these ships,” “exhaustion from work in fireroom,” or “heat and foul air.”(8)

Naval Assault on Charleston Harbor: Flying Boltheads and Fetid Air

Seven monitors participated in the unsuccessful attack on the fortifications in Charleston Harbor in April 1863. There were few casualties on the monitors, although men in the pilot house and turret must have felt that they were



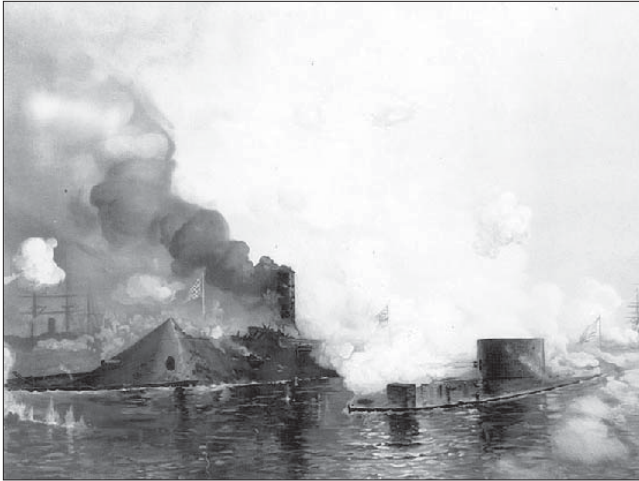
USS *Monitor*. Crewmen relaxing on deck, while the ship was in the James River, Virginia, on 9 July 1862. View looks forward on the starboard side, with the gun turret beyond. Note men playing checkers at right. Another man is reading a newspaper by the starboard smokestack. Also note dents in turret inflicted during fight with CSS *Virginia*.

under attack by their own vessel. Aboard *Nahant*, shot hitting the pilot house sent boltheads flying. One bolt struck the pilot “senseless” and another fatally fractured the skull of the helmsman. Flying bolts in the turret, which housed the crews of the Dahlgren guns, caused less serious injuries.(9)

Following the battle, the monitors were forced to lay offshore with hatches closed. Aboard *Passaic*, the crew suffered through 5 days of heat, dampness, constant rolling, and foul air “from the congregation of 80 men in so narrow a space.” Holden noted in his medical log that the “air is very bad and suffocating below...several of the crew prostrated with headache and mild cholera morbus owing to close atmosphere.” Such conditions, he wrote, “could not fail to enervate and sicken the healthiest crew.”(10) In surviving letters and reports to the Navy Department, monitor captains and squadron commanders repeatedly commented on the health risks aboard the vessels.

Ironclad Fever: A Mysterious and Fatal Malady

At War’s conclusion, Holden of *Passaic* published a report of a malady he called “ironclad fever.” Symptoms included occipital headache, aphonia, dyspnea, and rapid progression to coma and death. Typhus and “spotted fever” were considered, but there was no rash; some surgeons favored a diagnosis of cerebrospinal meningitis. In all there were some 40 cases, most fatal and all confined to the first few ironclads. Autopsies were conducted on two sailors from *Weehawken*, probably in mid-1863. Holden suspected toxicity from iron in the drinking water, which was often as “dark as coffee,” or some connection to the “imperfect ventilation.”(11) Our modern differential diagnosis might include sub-acute carbon monoxide intoxica-



USS Monitor in action with CSS Virginia, 9 March 1862. Aquarelle facsimile print of a painting by J.O. Davidson. Collection of President Franklin D. Roosevelt.

tion, heavy metal poisoning from water tanks, or a novel infection carried in the water or ventilation systems.

“The Healthiness of the Iron-clads”

The Union Navy was a healthy service, losing 1 in 50 men to disease, while the Army lost 1 in 12. Sailors benefited from strict qualifications for medical officers, a high ratio of doctors to crew, technical innovations, an established hospital system, and preparedness at the outbreak of hostilities.⁽¹²⁾ The Navy Department strongly supported the ironclad program. In December 1865, Gideon Welles, Secretary of the Navy, was pleased to transmit to Congress the conclusion of the chief of the Bureau of Medicine and Surgery regarding the “Healthiness of Iron-Clads.”⁽¹³⁾ Welles wrote: “The exemption from sickness upon the iron-clads in some instances is remarkable...the conclusion is reached that no wooden vessels in any squadron throughout the world can show an equal immunity from disease.”

The key to these seeming contradictions between the Navy Department and the men who served on the Civil War monitors lies in differing perceptions. While the Navy Department focused on reassuring mortality and hospitalization statistics, the officers and men were more concerned with daily misery and shattered constitutions—complaints that would not have been reflected in medical logs. Experienced wooden Navy men and new recruits alike were forced to adapt to an unfamiliar mechanical world. Their armored warship threatened them with foul fumes, flying bolts, unbearable heat or cold, and “adynamia.” Medical logs and hospital tickets demonstrate that monitor surgeons sympathized with the sufferings of the men, transferring them to hospital ships for exhaustion and confirming the service-related nature of their maladies. Life on the monitors may have been miserable, but

by the standards of the Civil War Navy, they were relatively healthy ships.

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Dr. Moss is a retired Navy internist, and resides in New Jersey.



“The Wreck of the Iron-clad Monitor.” Line engraving published in *Harper's Weekly*, 1863, depicting USS Monitor sinking in a storm off Cape Hatteras on the night of 30-31 December 1862. A boat is taking off crewmen, and USS Rhode Island is in the background.



The Odor of Mud

Mary Lee Sulkowski joined the Nurse Corps at Niagara University as part of the Navy's Nurse Corps candidate program. She went on active duty in 1963. Her first assignment was to Naval Hospital Jacksonville, Florida. A year later Vietnam "was becoming an issue," she recalls, and shortly thereafter, when she learned the Navy was about to recommission a hospital ship, she volunteered for duty and was assigned to USS Repose.

I received orders and reported at Hunter's Point in November of 1965. There were about 15 of us. The Chief Nurse was Angie Vitello, a very seasoned nurse. I don't know whether she had ever served aboard a hospital ship, but she certainly had a lot of experience in the Navy Nurse Corps. Most of us didn't know what to expect because we hadn't served in a war zone before aboard a ship. It was a lot of strategizing and talking about how we would adapt what we had learned stateside to the conditions we were going to encounter off the coast of Vietnam.

We sailed under the Golden Gate Bridge on January 2nd, 1966, then stopped in Hawaii on the way over. After stopping in the Philippines, we finally arrived on station in February. We took a few patients and then had to go into Subic Bay for about 3 weeks because there were problems with the engines. It was kind of a slow start but once we got back on station, we began taking a lot of patients.

I couldn't believe that I had gotten the assignment because there were so few nurses that got duty aboard hospital ships. I felt that that's why I joined the Navy. I had read stories about Army and Navy nurses when I was a little girl, and part of the adventure was that you served in a war zone. It seemed, at the time, very exciting and quite an adventure.

But there was another whole side to serving in a war zone. It really didn't hit you till later. And it was something you could never really prepare for.

I think part of it was being young myself and taking care of young men that were even younger than I was. The average age of the soldier, sailor, or Marine who served in Vietnam was 17, 18, 19. It was a shock, all of a sudden, to be confronted with very serious life-threatening injuries and illnesses and being in a position of being responsible for giving the best care.

I've heard it said that the Vietnam War was actually two wars. The first part was before 1968. That year and the following year—1969—the war became a much different issue as the disillusionment and the reality of Vietnam set

in. In 1965 and 1966 we were still very idealistic as to why we were there.

One of my strongest impressions of that duty was how concerned the young patients were about each other. We'd get a rush of patients--30 patients on a unit at a time. I would be told: "Take care of him, he's in worse shape than I am." Or I would hear: "Do you know what happened to my buddy? Did he make it aboard?" These questions have stayed with me the longest.



A helicopter's-eye view of Repose's flight deck.

Photos from BUMED Archives

I don't have a good memory for details, but I do remember impressions and feelings. At times, it was almost boring when there was a lull and we weren't taking on new patients. It would become very routine, and people were hopefully getting better. And then when an operation suddenly began ashore, things would change completely in a moment and we began receiving casualties. It could go from a lull to being incredibly busy.

Because the casualties arrived on the unit in their fatigues and boots just as they were medevaced from the field, there was a peculiar odor. It was the mud. God only knew when those fatigues had last been washed.

We had to go through the uniforms pretty quickly to make sure there weren't any weapons, particularly grenades in the pockets. Then we'd line the boots up outside the ward in the hallways. It was a real sign of how many casualties our ward had taken that day because suddenly there were 30 muddy combat boots lined up reeking of Vietnam mud.

I worked for most of the time on C-3, a large surgical unit that could accommodate 60 or 70 patients in triple tiers of bunks. The most serious were placed on the lower bunk. It was a sign that a patient was getting better if he went up a bunk. By the time he could hop up to the third bunk, he was doing pretty well.

We might be scheduled for an 8-hour shift but if the casualties were coming in, we'd just keep working. I recall some 12-hour shifts. People would come back after a couple of hours of sleep and start working again as the need existed. I think personal politics, which can sometimes interfere in a working situation, were probably negated in this situation because I so much appreciated people who were generous enough to give of themselves and keep working.

When the patients first came aboard the *Repose*, it was a relief for them to get out of the war zone and to be in a clean white hospital. Not only was the outside of the ship white, but we had white bed linens, nurses in white starched uniforms, air conditioning, ice cream--the perks of getting aboard a hospital ship, let alone the medical care. Their faces said it all.

When I left the ship after 11 months, it was a very emotional time. I was one of the first nurses to leave. I got orders for recruiting duty in October of 1966 and flew off the ship to Chu Lai. I then flew to Danang with some of the men who had been my patients aboard the *Repose* and were now going back to duty in Vietnam. If you could be rehabbed within 30 days, you went back

to your unit. So I was leaving and they were going back into combat. And I had been there long enough to know what they were going back to. One of the saddest memories I have is seeing their faces. They knew what they were headed for, and they also knew that they might not make it back again.✍

Ms. Sulkowski left the Navy but stayed in the health care profession, working for the Veterans Administration as a psychology nurse. She resides in Buffalo, NY.



Nurse Carol Burton Johnson cares for a patient aboard USS *Repose*.

A Look Back at Four Navy Physicians and Their Presidential Patients

Ludwig M. Deppisch M.A. M.D.

Since Surgeon Bailey Washington's ministrations to President James Madison in 1813, Navy medical officers have had a long and significant history treating American presidents. Four of these served as the highest ranking physician in the Navy (i.e., Chief of the Bureau of Medicine and Surgery (BUMED) and Surgeon General of the Navy); of these, two served simultaneously as the Navy's top doctor and the president's personal physician. The following narrative offers a glimpse of the unique and fascinating careers of these Navy medical professionals.

Thomas Harris (1784-1861)

Chief of the Bureau of Medicine and Surgery (1844-1853)

In early 1832, while on temporary duty in Washington, DC, Navy Surgeon Thomas Harris was called upon to extract a bullet from the left shoulder of President Andrew Jackson. Jackson, apparently cognizant of the doctor's surgical expertise honed in sea battles during the War of 1812 and in treating wounded sailors at Naval Hospital Philadelphia, PA, commandeered Harris to perform this operation. The bullet was an artifact of a gunfight that occurred in downtown Nashville, TN, almost 20 years earlier. According to an account in the *Boston Globe*: "The President occasionally...suffered much from the wound in his arm. Recently, the ball which fractured the bone, and remained in the muscle, has produced great irritation, and affected sympathetically the muscles of his shoulder and back."⁽¹⁾ The surgeon returned to his post in Philadelphia shortly thereafter.

Harris' relationship with his presidential patient, albeit transient and brief, had long lasting results. President Jackson's shoulder symptoms disappeared and his chronic lead poisoning, a result of the long residence of this lead projectile in the metallic-leaching synovial fluid of his shoulder joint, disappeared.⁽²⁾ Furthermore, the then ex-president favorably remembered his doctor in an 1844 letter to Francis P. Blair, a friend and fellow patient: "All

congratulate you in your returning health and the skill of that good Doctor Harris--may you live long."⁽³⁾

Harris became Surgeon at the Philadelphia Navy Yard sometime after the War of 1812. While there, he developed, organized, and directed a postgraduate medical school, the first American school to provide education specific to Navy medicine. Between 1823-1843, nearly all navy medical officers received instruction at this school. Harris' surgical expertise was recognized by the civilian Philadelphia medical community; he was appointed to the teaching faculty of the University of Pennsylvania School of Medicine.

On April 1844, President John Tyler appointed Harris to the position of Chief of the Bureau of Medicine and Surgery (BUMED) a post Harris would hold until ill health forced his resignation in 1853.⁽⁴⁾

Jonathan M. Foltz (1810-1877)

Surgeon General of the Navy (1871-1872)



André Sobocinski Collection

An assistant surgeon who served in Philadelphia under Harris, and one who undoubtedly benefitted from instruction at the navy postgraduate school, was Dr. Jonathan Messersmith Foltz.⁽⁵⁾ Foltz had a long, distinguished, and eventful medical career, beginning with his appointment as assistant surgeon in 1830

and culminating in his service as Surgeon General of the Navy and Director of BUMED in 1871-1872.⁽⁶⁾ During his career, Foltz was physician to two presidents: James K. Polk, briefly, in 1848, and James Buchanan, both prior and during his presidency (1857-1861).

Foltz's 1848 assignment to the Washington Naval Yard was described: "During this period of service in Wash-

ington, Doctor Foltz found himself drawn into strange and turbulent currents of political life, for President Polk, whose health was beginning to give way, often summoned him for medical advice and others in high place followed suit.”(7) In midsummer 1848, the weary president asked Foltz to accompany him to Bedford Springs, PA, where he might benefit from its curative waters. During this trip, the doctor’s role was more that of a concierge than that of physician.(8)

Foltz’s relationship with Buchanan was a complex social, political and medical mix. Buchanan and Foltz both hailed from Lancaster, PA, a town whose size permitted social familiarity. The young doctor Foltz had requested a letter of reference from Buchanan, Lancaster’s most prominent citizen, for admission to the Navy’s medical service. In 1847, while recovering from Mexican War duty at Naval Hospital Newport, RI, James Buchanan, then Secretary of State, contacted Foltz to treat a nasal polyp without operating. According to his biographer, Foltz looked upon this as a command and immediately set out for Washington. Upon his arrival: “For the convenience of treating his case, he desired me to live in the house with him, where I took up my quarters and remained with him for many months.” Buchanan expressed his appreciation and urged his physician to renew their social intimacy at every opportunity.(9)

In 1849 Buchanan, who had continued to claim Doctor Foltz’ medical services for various ailments, went to the doctor’s quarters at the Washington Navy Yard for surgical treatment, presumably the removal of his nasal polyps. Buchanan “quietly remained there for some days, while his friends were mystified by his disappearance, no one else knowing what had become of him.”(10) Foltz’s interest in continuing a physician-patient relationship with Buchanan was more than medical; the relationship had been “...stimulated by telling (Foltz) that he would be chief of the Naval Medical Bureau.”(11) In late January 1857, President-elect Buchanan asked Foltz, then in Lancaster for a visit, to accompany him to Washington, “again remarking that he was to be chief of the Naval Medical Bureau...Foltz told him that he did not seek that office, but the President-elect declared that it was fully determined, and added that he ‘must have Doctor Foltz in Washington to look after his own health’: he must go with him to Washington ‘to look over the ground’ with a view to his duties in the Bureau.”(12)

Foltz’s skill as Buchanan’s medical attendant was required both in Washington, and later in Lancaster, to combat “National Hotel Disease,” a gastrointestinal illness

acquired at the Washington hotel of the same name, which felled many and killed several. Buchanan again insisted that Foltz accompany him to Washington, this time as his medical attendant during his inauguration ceremonies. The doctor’s contemporary letters to his wife are revealing: “He has not been very well, and I have stuck closely to him throughout all the proceedings of to day...and, at his request, accompanied him to the White House and am now writing from my room, which adjoins his...” On March 8 he wrote: “The President improves so slowly that he still requests me to stay with him...” Daily letters continued, which noted that the Secretary of the Navy had extended the Surgeon’s leave of absence from his usual post at Mr. Buchanan’s request.(13) Unfortunately Foltz became disillusioned with his presidential patient, since: “His own unsolicited, but often promised, appointment as Chief of the Bureau of Medicine and Surgery had failed to materialize...” Buchanan for a while maintained “a most cordial attitude towards Surgeon Foltz, [but] disappointed both the expectations of preferment which [Buchanan] himself had planted and the faith in [Buchanan’s] sincerity, courage, and patriotism so firmly held.” Foltz was often in Washington during the first half of 1858, and the president always insisted that he stay at the White House, in the room next to his own. Buchanan explained to the doctor that “irresistible influences prevented him from doing as he had intended, both in his appointments and his policies.” The inevitable break in the relationship occurred in midsummer 1858.(14)

Twenty years later, after a distinguished career that included service in the Civil War, Foltz was recalled to Washington in October 1871, to be appointed Surgeon General of the Navy. The term of this office was short “for it was an honor coveted before retirement.” On April 25, 1872, Foltz reached the age of retirement fixed by law and presented his resignation.(15)

Presley M. Rixey (1852-1928)

Surgeon General of the Navy (1902-1910)

In his memoir, Vice Admiral Ross McIntire, later to appear in this narrative, called Jonathan Foltz the first regular White House physician.(16) However this designation more accurately fits Navy Surgeon, and later Rear Admiral, Presley Morehead Rixey, who was White House Physician under Presidents McKinley and Theo-



BUMED Archives

dore Roosevelt from 1898-1908, and Surgeon General from 1902-1910.

Dr. Rixey was stationed at the Naval Dispensary in Washington, DC, from February 21, 1882 to September 18, 1884, from November 15, 1887 to January 5, 1893, and again commencing on December 10, 1895 “during which periods he made many staunch friends...which was to stand him in good stead in later years.”(17) In the late 19th century, Navy medical officers were able to supplement their inadequate salary with private practice. Rixey’s patients included many prominent figures, including Vice President Garret Hobart, Secretary of State John Hay, senators and congressmen, and more beneficially, several Secretaries of the Navy.(18)

In the fall of 1898, Navy Secretary John Long, one of Rixey’s illustrious patients, asked President McKinley if he intended to take a physician on a trip to Atlanta, GA. Long’s concern was directed towards his own sickly daughter and the president’s epileptic wife, both of whom would be part of presidential party. President McKinley saw the need for a physician and had Dr. Rixey accompany the party to Atlanta. Soon after, Rixey was given the post of White House physician.(19)

In this role of White House caregiver, Dr. Rixey’s was required to make daily trips to the White House, accompany all presidential trips, and be in attendance at all special presidential occasions. When Rixey was out of town, his naval assistant carried on the work at the dispensary and Rixey’s private patients were turned over to his friends in the profession. The White House physician’s medical attention was focused almost exclusively upon Mrs. McKinley.(20) “It is not surprising that, by his tender devotion to this patient and by the efficient management of her case, Dr. Rixey endeared himself beyond measure to the President--nor is it to be wondered at that, during the trip East...the President voluntarily promised the doctor that, upon the first occurrence of a vacancy in the Office of the Surgeon General of the Navy, he would appoint him to that vacancy.” In subsequent private conversations with the doctor, the President occasionally referred to this promise.(21) However, McKinley’s assassination at the Pan-American Exposition in Buffalo in 1901 delayed its fulfillment.

Dr. Rixey was a prominent presence in the primitive operating room of the Pan American Exposition’s dispensary, where an attempt was made to repair the president’s abdominal injuries. Since the operating room was not equipped with lights, Rixey held a mirror to reflect the setting sun’s rays onto the surgical field. The presiden-

tial physician later directed the medical team that managed McKinley’s ultimately unsuccessful postoperative course.(22)

“These two gentlemen (Secretaries Long and Wilson) took it upon themselves to acquaint Mr. Roosevelt with Mr. McKinley’s desire in the matter before leaving Buffalo.” “Mr. Roosevelt respected that legacy and fulfilled the promise in memory of his beloved predecessor.”(23) Rixey’s appointment as Surgeon General occurred in 1902 and his tenure extended until 1910. Its achievements included several new hospitals, the doubling of the size of the Medical Corps, the establishment of the Navy Nurse Corps, and a new focus on tropical medicine.(24) Rixey, then an admiral, developed a very close personal and recreational relationship with the athletic Roosevelt; this certainly added to the success of his Surgeon Generalship.(25)

Ross T. McIntire (1889-1959)

Surgeon General of the Navy (1938-1946)

Another White House Navy Physician, Rear Admiral Cary Grayson, who served as President Woodrow Wilson’s personal physician confidant, was responsible for the appointment of the fourth doctor featured in this narrative: Navy surgeon Ross McIntire. Grayson was McIntire’s commanding officer when the latter was assigned to the U.S. Naval Dispensary in 1925; the acquaintance was renewed when McIntire was stationed at the Washington Naval Hospital in 1931.(26) When President Franklin Roosevelt asked his friend Grayson to recommend a White House physician, Grayson recommended his protégé. McIntire, a trained otolaryngologist, expressed anxieties about his general medical expertise. Grayson told his friend to cease his concern: “The president is as strong as horse with the exception of a chronic sinus condition that makes him susceptible to colds. That is where you come in.”(27)


For a dozen years McIntire monitored FDR’s general health, especially his sinuses. McIntire developed a routine, parking his car outside the White House around 8:30 each morning and then walking to the president’s bedroom for a “look see.” There was no stethoscope, examination, or direct questioning. After departing to do his routine work, McIntire returned to the White House promptly at 5:30 for a more direct history taking. On presidential trips, the doctor usually gave the president an “once-over” at bedtime.(28)

In 1938, McIntire took on the duties of Surgeon General. With the outbreak of World War II, he had dual role: primary responsibility for the health of FDR that included

traveling with him on diplomatic missions and on military inspection trips and presiding over the largest Navy Medical Department in history--over 175,000 physicians, nurses, and corpsmen.(29)

However, Roosevelt's health deteriorated severely after the Teheran Conference in late 1943. McIntire was not up to the medical challenge, but he more than overcame the political challenge, blithely lying about the president's hypertension and congestive heart failure. It took the dramatic revelations by Navy cardiologist Howard Bruenn many years later to refute the many misleading statements made by McIntire both in his news conferences and in his memoir.(30)

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An Ugly and Forbidding Place

William Bailey joined the Navy in 1941 based on the advice of a cousin, who told him he'd live a lot better there than in the Army. "He told me to tell the recruiter that I knew everything about first aid and that I should be a hospital corpsman. According to my cousin, corpsmen always stayed inside, drank coffee all the time, and never had outside watch."

After boot camp, Bailey was assigned to Naval Hospital Annapolis, MD, but was not there very long before he received orders to the Fleet Marine Force and sent to Camp Lejeune to learn basic combat skills.

He soon shipped out to the West Coast for more training before sailing for the Pacific aboard the troop transport, USS LaSalle (AP-102) on New Year's Day 1944. The young corpsman then participated in the landings on Kwajalein, Roi-Namur, Saipan, and Tinian. His next campaign was Iwo Jima, although he had no idea where he was going at the time.

When we left Pearl Harbor, we found out where we were going. On the way to Iwo Jima we stopped in Saipan and anchored there for 24 hours. Iwo was halfway between the Marianas and Japan.

Iwo Jima was the ugliest and most forbidding piece of land I'd ever set eyes on. There were no trees on it, nothing whatsoever. It looked like the sand was smoking. I could see the air strikes very clearly and the Japanese artillery firing back at us. Our ships pounded it around the clock. Planes dropped napalm and bombs. It was a constant bombardment.

I did not go ashore on the first day but instead rode landing craft—LCIs [Landing Craft Infantry] and LCVPs [Landing Craft Vehicles and Personnel] that picked up wounded and brought them back to the ships. I did this for 3 days. Our job was to evacuate casualties and bring them back to the ships where they could be treated. But before we did that, many of them needed immediate care.

If a man was hit, we bandaged him to stop the hemorrhage as best we could. We then gave him plasma, a shot of morphine, got him aboard a landing craft, and then out to a ship as fast as we could. We were under fire going in and coming out.

There were two LSTs anchored about a mile off the beach. Both were designated as LST(H)s and were used as hospital ships. If we had men in bad shape and needed transfusions, oxygen, or anything we couldn't do for them on board that little craft, those LST(H)s would take the men and take care of them.

When we first arrived alongside a larger ship with casualties, at first the patients were lifted aboard one at a time, but the injured men would bang up against the ship. Finally, a new method was developed. Two hooks were lowered from the ship's davits, one at the bow, the other at the stern. The crew of the landing craft would then attach the two hooks,

and the entire LCVP was hoisted to the level of the railing. Then members of the crew took the wounded aboard. One time the man up in the bow of our LCVP had hooked on successfully but the guy in the stern missed his hook. When the crew of the larger vessel started lifting, we began hanging at a 45-degree angle. I reckon we had 10 or 12 men roll right on top of each other off their stretchers. As badly hurt as they were, I'm sure some of them were killed. They dropped us down immediately so we could hook on, but by that time the damage had been done.

On the third day, my whole unit—E Medical Company—went ashore, moved up the island, and set up our company hospital right at the end of a runway. We were just clear of it. Anytime a plane came in we'd see it. Nearby was a cistern the Japanese had used to collect rainwater. The Seabees pumped it dry, knocked down one corner, ground it down, and covered it with 2 by 4s and a heavy tarpaulin to make it light-proof. It became our operating room. There was no ventilation except what air managed to get in there. It was miserable but that's where we operated on the absolute worst casualties.

Some big shell hole offered a depression for another tent. The dirt around it was piled high so it couldn't be seen from the other part of the island.

We also set up long ward tents as receiving stations. Today, much of what we



Sailors transfer casualties to a troop transport.

Photos from BUMED Archives

did would be considered major surgery. Sometimes we'd amputate a leg or repair an intestine. We did what had to be done.

Before long we were receiving whole blood. The first 16 or 18 pints arrived in a wooden box secured with a styrofoam type of material and dropped by parachute. Each box had a little compartment right in the center containing enough dry ice to keep the blood cool. That styrofoam-like material surrounding the bottles of blood was about 6 inches thick. Once planes were able to land on the island, we got all the blood we needed.

This blood was a great improvement over the plasma we had been using because it contained red blood cells, which instantly began providing oxygen and nutrients to the body. The plasma gave the injured man the liquid he needed to keep him alive but that's about all. When we started getting red blood, we began using it by the ton.

A Marine captain was brought in with his leg just hanging by a little tissue. I cut the leg off myself with a scissors. He had stepped on a land mine, which almost blew half his butt off, and was bleeding like crazy. We had two bottles of blood going at one time. He ended up receiving 18 pints! Let me tell you, he was almost a dead man but damn lucky.

We were restricted to our area because there was no time for anyone to be gawking around. We had work to do. We handled wounded men right up to the minute we left Iwo to go back aboard ship. There was no time for sightseeing.

Because Iwo Jima was volcanic, there were hot spots all over the island. There were places you'd dig in at night and then have to move your foxhole because the ground was so hot you couldn't stay there. You'd freeze on one side and burn up on the other. If we wanted to heat our C-rations, we'd simply dig a hole about 2 feet deep, throw in a dozen cans of C-rations, cover the hole, stick an entrenching tool on top so we could find it, then wait an hour and dig up the cans. They were so hot, you could hardly hold them. And if we forgot where the hole was, they'd overheat and blow up.

One morning I was heating some coffee when three P-51s that had landed a day or two before were taking off. The lead plane must have hit a soft spot on the runway because it began wobbling and the wings tipped and hit the ground. Suddenly the plane cartwheeled end over end. When we reached the plane, the pilot was sitting in the cockpit laughing. He didn't have a scratch. All that was left of the plane was that cockpit.

The reason we took Iwo Jima was to have a place for crippled B-29s to land. No one could have wanted that place for any other reason. I saw the first B-29 come in with a hole in the wing big enough to drive a jeep through. Let me tell you. That plane was impressive! I had never been that close to one before and couldn't believe how big it was.

I was on Iwo until the 28th of March with the first uniform I started with—and no bath. I brushed my teeth and shaved maybe once every 4 or 5 days when there was enough water. Water was very scarce, especially the first 10 days. I'll tell you, that was a smelly crowd when we left there. ⚓



Whole blood flown from the United States goes aboard a transport for immediate delivery to Iwo Jima. The availability of whole blood during that campaign made a big difference in the treatment of combat casualties.

IWO JIMA STATISTICS

Navy and Marines:

KIA: 5,841 (26.9 percent on duty)

Wounded (subsequently died): 662 (3.1 percent on duty)

Invalided from service: 3,099 (16.0 percent on duty)

Hospital Corps:

KIA: 202

Award Recipients (Navy medicine)

Medal of Honor

Hospital Corps: 2

Navy Cross:

Hospital Corps: 14

Medical Corps: 2

Silver Star:

Hospital Corps: 109

Medical Corps: 11

Bronze Star:

Dental Corps: 4

Hospital Corps (Officers): 5

Hospital Corps (Enlisted): 291

Medical Corps: 70

Legion of Merit

Medical Corps: 4

Navy and Marine Corps Medal:

Hospital Corps: 2

Medical Corps: 1

Commendation Ribbon with Medal Pendant:

Dental Corps: 2

Hospital Corps (Officers): 1

Hospital Corps (Enlisted): 33

Medical Corps: 17

Navy Medicine 1945



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PhM2c John Bradley receives the Purple Heart for wounds incurred at Iwo Jima. RADM William Chambers, MC, USN, made the presentation at the National Naval Medical Center Bethesda, MD.

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