ARMY MEDICINE
Bringing Value...Inspiring Trust

MERCURY

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High five

MAJ Patrick Smock, an orthopedic surgeon with the 745th Forward Surgical Team, gives a high-five to Abas, a 9-year-old Afghan boy who is being treated for severe burns to both legs by 426th Brigade Support Battalion medics at Forward Operating Base Fenty.

Smock said Abas has become a long-term patient at the aid station because his legs became infected when he returned home.

"His home environment just isn't quite hygienic enough for him to stay there without his wounds getting infected. Nutrition is also a factor," Smock said. Abas' family visits him regularly.

"The end goal is for him to be up walking again," Smock said. "However that's several months away, because his wounds will need to completely heal. He'll probably need additional surgery because his knees are contracted in a partially-flexed posture." (Photo by SSG Ryan Matson/Army News Service)

Reserve general to lead DoD Health Affairs

The nomination of BG Jonathan Woodson to be assistant secretary of defense for health affairs was confirmed by the U.S. Senate in December. Woodson was previously the Army's assistant surgeon general for reserve affairs, force structure and mobilization, and deputy commander of Army Reserve Medical Command.

During his confirmation hearing before the Senate Armed Services Committee, Woodson pledged to draw on his vast experience as a military medical officer and leader, health-care administrator, teacher, researcher and physician to tackle the challenges confronting the military health system.

Woodson said he will work collaboratively with other Defense Department components, federal agencies and civilian organizations while striving to advance military health, its mission and its benefits to its beneficiaries.

Woodson said he looks forward to the opportunity to enhance medical readiness and provide the level of care military members and their Families deserve.

"I have always been personally inspired by the commitment and dedication of those Soldiers, sailors, airmen, Marines and Coast Guardsmen," he told the Senate panel.

With deployments to Saudi Arabia, Kosovo and the U.S. Central Command area of operations under his belt, Woodson said he will give particular emphasis to improving care for wounded troops.

"The highlight of my career as a surgeon has been caring for the wounded warrior on the battlefield," he said. "These talented young men and women who have been asked to shoulder the responsibilities of defending this nation and have suffered the consequences of nearly a decade of war deserve the best medical care, both at home and abroad."

Woodson said he will work with Congress

BG Jonathan Woodson

and other agencies to find the most effective strategies for preventing suicide and preventing and treating post-traumatic stress disorder and traumatic brain injuries.

He said he also looks forward to working with Veteran Affairs Secretary Eric K. Shinseki to streamline the medical evaluation board disability evaluation system and provide smoother transitions when troops transfer from the Defense Department to VA systems.

Woodson paid tribute to the medical professionals "at the heart and soul" of the military health system.

"These true professionals have soldiered alongside their combat-arms colleagues and acted as force multipliers," he said. "They deserve not only accolades, but real assistance in helping them perform their jobs better and more efficiently."

Toward that end, Woodson said, he'll expedite the introduction of electronic health records that enhance health-care providers' ability to deliver quality care.

Woodson expressed confidence that the Defense Department medical system can establish new models that the civilian sector will want to emulate in the delivery of quality care — which he defined as "the right care, at the right time, in the right amount, at the right cost that is safe and patient-centered."

Woodson, a brigadier general in the Army Reserve, has served as associate dean for diversity and multicultural affairs and associate professor of surgery at the Boston University School of Medicine and senior attending vascular surgeon at the Boston Medical Center.

In 2007 he was named one of the top vascular surgeons in Boston and in 2008 and listed as one of the top surgeons in the U.S. He was the recipient of the 2009 Gold Humanism in Medicine Award from the Association of American Medical Colleges.

His military assignments include; surgeon, 373rd General Hospital; surgeon, 351st General Hospital; surgeon, 86th Evacuation Hospital, Saudi Arabia (Operation Desert Storm); observer/trainer, Hospitals Integrated Lanes Training Program, 87th Maneuver Area Command (MAC, Div. E); surgeon, 399th Combat Support Hospital, chief, professional services/deputy commander, 399th CSH, acting commander, 399th CSH; professional liaison officer, 804th Medical Brigade, chief of surgery, Task Force Medical Falcon, Kosovo; chief, professional services/deputy commander, 865th CSH (Forward deployed, Operation Enduring Freedom, Operation Iraqi Freedom); commander, 399th Combat Support Hospital, Taunton, Mass.; and commander, 330th Medical Brigade, Fort Sheridan, Ill., with additional duties as consultant to The Surgeon General. (Adapted from American Forces Press Service)

MERCURY Comment

Command corner

Patients deserve special appreciation

by LTG Eric B. Schoomaker
The Surgeon General of the Army and Commander of Medical Command

Patient Recognition/Appreciation Week is nationally celebrated the week of Feb. 1-7. This national commemoration is a time for us to recognize and appreciate you, our patients — Soldiers, retirees, and Family members. We want you to know you are the most important partner in our relationship. Every day, the men and women in Army Medicine work to provide you the very best system of health. We value you and your trust in us.

In Army Medicine, we are devoting the entire month of February in recognition of our partnership with you, our patients, and in appreciation of your sacrifices and contributions. This is our time to reflect and renew our commitment to you. We are dedicated to your good health through maximized physical and behavioral health promotion; we strive to deliver the highest quality of care based on best practices and outcome-focused services. We aspire to create the best healing environment focused on Mind, Body, and Spirit and to improve your access and continuity within our Army Medicine system of care.

As part of Patient Appreciation Month, our military treatment facilities (MTFs) will be conducting a variety of events/activities, please take advantage of these opportunities and learn more about the medical treatment facility in your community.

On behalf of the entire Army Medicine Family, we thank you!

Army Medicine: Bringing Value…..Inspiring Trust.

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In Appreciation…….

I am privileged to express my heartfelt thanks to Mr. Jerry Harben, editor of the Mercury newspaper for 27 years. On Feb. 2, Jerry officially retired from civil service. For 32 years, Jerry has served his nation faithfully and been a huge contributor to Army Medicine's success. I want to personally wish Jerry and his wife, Sunie, much happiness and good health in retirement. Jerry's unwavering support and commitment to Army Medicine will be truly missed. Good luck and God Speed, Jerry.

Behavioral patient learns it's OK to seek help

by Jennifer Walsh Cary

When it comes to mental health, I've noticed that most people prefer not to talk about it. It's almost as if bringing up the topic somehow implies they're suffering from mental-health problems.

It's an unfortunate stigma that continues to plague our military communities. A stigma, I believe, that people will have to overcome individually.

First step? Know what to expect.

Recently, I put myself to the test and requested to go through the entire mental-health process as a patient. My goal was to shed light on what actually happens behind closed doors in mental health.

Just like routine

Truthfully, it was like a routine medical appointment. Anti-climatic, I know.

The waiting room was full of people just like you and me. Maybe they were suffering from stress because their spouse is deployed or maybe they were having some anxiety because their finances weren't up to par. I reported with general stress. With a deployed spouse, a full-time job, the chore of buying winter tires and a dog that goes to the vet more than I go to the doctor, who wouldn't be a little stressed?

With mental health, you don't have to make an appointment so I walked up to the counter and was given a stack of paperwork to fill out. Most of it was privacy information. I learned that unless I intended to harm myself or others that the conversation with the provider would stay between the two of us. It was a huge relief. Maybe it shouldn't be a big deal, but I wouldn't want my employer or anyone else to know I was there; just like I wouldn't want my employer to know if I was being treated for heat rash. It's no different in my book.

Since I didn't have an appointment, a nurse called me to her office to prescreen me. She asked a lot of questions — most of which were required — and determined which provider I needed to see. There were a couple of questions that I didn't expect, like have I had thoughts of killing myself or was I having delusions.

After the brief interview, I went back to the waiting room. As I approached the counter to turn in my paperwork, I saw one of my co-workers in the hallway. Instantly I wanted to find a place to hide. All I could think was that every time I see him from this point forward he'll be thinking, "better be careful, this one is crazy."

Clearly, I am not immune to the stigma. And while my gut reaction was to run, I decided to stay. Even though it was difficult, I was determined to beat the stigma.

Venting

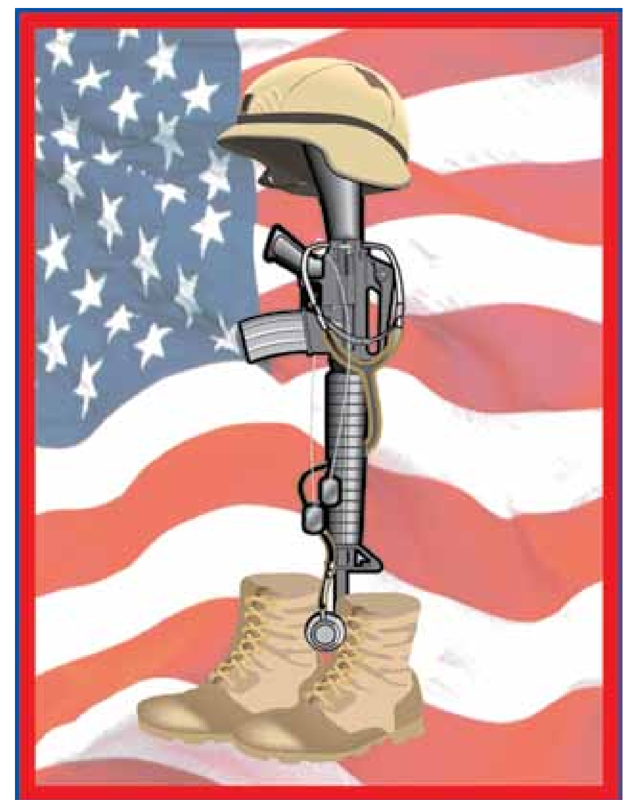
Eventually I went back to the provider's office and we talked for almost an hour. I was surprised at how much stress I put on myself. I was also surprised at how much I enjoyed venting about it to a neutral party.

Sure, I vent to my mom or my husband or my friends — I definitely don't internalize my feelings — but this was somehow different. I could say anything and it was met with open interest and without judgment.

It was awesome.

Afterward, I still felt like myself. I wasn't ashamed for going and if I ever feel like I need someone to listen, I won't hesitate to call this provider. For someone who wanted to run and hide when I was "spotted" an hour earlier, it says a lot about the quality of care I received.

Overall, the idea of seeing a mental-health provider can be intimidating or a little scary, but in reality it's like a routine medical appointment. The real challenge is facing your personal stigma against mental health. I can tell you from experience that the care you receive is well worth the stress of fighting the stigma. Now more than ever, I believe it's OK to seek help. (MEDDAC Bavaria)



The last, full measure of devotion

PFC Jacob A. Gassen, 68W, 1st-61st Cavalry, Nov. 29, 2010

SGT James A. Ayube II, 68W, 3d-2nd Stryker Cavalry, Dec. 8, 2010

Mercury

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System expands for improved disability exams

by Karen Parrish

A pilot program that eases medical separation and speeds benefit payments for service members too wounded, sick or injured to stay in the military will soon roll out to the entire force.

"We are proud that the disability evaluation system is making progress," a senior defense official said. "Our people are committed to not only expanding this faster disability system, but we are just as committed to making it even faster and fairer for our transitioning service men and women — our work here is not done."

John R. Campbell, defense deputy undersecretary for wounded warrior care and transition policy, said the Integrated Disability Evaluation System is a joint effort between the Defense and Veterans Affairs departments.

"The events in February 2007 around Walter Reed triggered the DoD and the VA to really take a look at what they had been doing," Campbell said. "That process then continued to where we are today."

The program will expand to all military medical sites across the services by October 2011, he said.

In the past, separating service members got end-of-service physicals and final military treatment from local military medical clinics while still on active duty. After separation, troops seeking disability compensation would have to repeat the same examinations at VA facilities, and then wait weeks or months for a disability determination before they could request disability benefits.

"The legacy system had both DoD and VA as components, and the VA started only after the DoD [evaluation] was complete. So it took up to 540 days for the whole disability evaluation system to work," Campbell said.

The new program brings together VA and military medical separation processes while service members are still on active duty.

Under the new system, wounded, ill or injured service members receive medical evaluations by VA-certified doctors using VA guidelines, while DoD uses these exams to determine if a service member is able to continue in uniform.

The pilot program has been operating in 27 sites, and Campbell said the system now takes about 300 days to evaluate service member disabilities.

For service members, the process is faster, with only one set of examinations to complete, and fairer than the previous system, Campbell said, with all evaluations done through one set of protocols.

Campbell said the net result for medically-separated service members is they can receive a disability rating while still on active duty, and receive disability compensation after their first full month in veteran status, the soonest allowable by law.

Results from the test sites have been great, he said.

"We're getting much higher satisfaction ratings from discharged service members and their Families," Campbell said. "[They say] this system is just far superior to the legacy system." (American Forces Press Service)

Best friend

CPT Kristina Pugh, branch chief of Fort Riley, Kan., veterinary services, and Kenton Tully, a computerized tomography radiology technician at Fort Riley MEDDAC, perform a CT scan on Jasko, a military working dog for the 500th Military Police Detachment. The scan helped diagnose the cause of progressive lameness and pain in Jasko's hind legs. (Photo by Alison Kohler/Fort Riley)

Assisting patients earns awards

by Lidia Vasquez

Nadine Hill of Heidelberg, Germany, MEDDAC, was selected as the 2010 Army Medicine Beneficiary Counseling and Assistance Coordinator (BCAC) of the Year. Kimberly Everett of Guthrie Army Health Center at Fort Drum, N.Y., is the 2010 Debt Collection Assistance Officer (DCAO) of the Year winner.

They were honored for extensive knowledge of the Military Health System and relentless dedication in responding to the needs of beneficiaries. A BCAC educates beneficiaries, and enhances a thorough understanding of TRICARE programs. A DCAO provides assistance with debt collection matters concerning unpaid TRICARE claims.

The awards are given annually by Medical Command to recognize two individuals for outstanding contribution as a BCAC and DCAO. The regional medical commands submitted their nominations and MEDCOM convened a special board to select the winners. Each winner receives a monetary Special Act Award.

Other regional BCAC nominees were Suzanne Mosier of Fort Campbell, Ky., MEDDAC; Tiffany Dipman, of Fort Leavenworth, Kan., MEDDAC; Irene Brooks of Fort Knox, Ky., MEDDAC; and Cheryl Keopuhiwa of Schofield Barracks Army Health Clinic, Hawaii.

Other DCAO nominees were Marguerite Watzek of Fort Campbell, Ky., MEDDAC; Aubrey Hendrix of MEDDAC Alaska; and Rocco Morano of Tripler Army Medical Center, Hawaii. (MEDCOM TRICARE)

Month promotes patient appreciation

National Patient Appreciation Month and National Patient Recognition Day (Feb. 3, 2011) are an opportunity to pay special tribute to those Soldiers, Family members and retirees who make up the Army-wide patient community.

Patients in Army medical facilities deserve the finest treatment in an environment where they are valued, empowered and confident in the skills of Army medical professionals.

Improved communication and patient satisfaction are a continuing focus for all Army medical care leaders. There remains no higher priority for Army medical-care providers than ensuring the physical and behavioral health of the Army Family.

During National Patient Appreciation Month, the Army will recognize the unique needs of Army patients and ensure they understand the Army's commitment to the highest standards in patient-centered care.

The quality of Army medical care, from the battlefield to the home front, is world class. Expert delivery of trauma care in the field saves the lives of nearly 90 percent of wounded Soldiers.

Throughout the Army, across the continuum of care, patients receive individualized treatment, support and services addressing both physical and behavioral-health needs. Army medical professionals and staff are recognized for top-notch skills and for leading the way in providing innovative patient care.

The Army patient community benefits from forward-edge Army medical research in areas from post-traumatic stress treatment to prosthetic technology. The Army teams with the Department of Veterans Affairs, other government agencies and the world's finest research institutions to give wounded warriors the best care and support possible.

The Army continues to expand the resources and personnel dedicated to the care of patients and their Families. Providing quality medical care and support services is a top priority.

The Army must make every effort to ensure Soldiers, Families and retirees are aware of the medical-care programs available to them. The Army puts the interests of patients first, every day. (MEDCOM Strategic Communication)

Scientists seek answers to HIV threat

by Cheryl Pellerin

The U.S. Military HIV Research Program (MHRP) at Fort Detrick, Md., seeks to protect troops everywhere from HIV infection, and also works to reduce the disease's global impact.

The program has contributed to recent successes against the pandemic that kills 5,500 people a day, said COL Nelson Michael, director of the institute's retrovirology division.

Advances include using antiretroviral drugs to control HIV infection; prevention tools like condoms, microbicides as a tool to help women prevent HIV infection, circumcision to reduce infection risk to men for heterosexual sex; and the use of a daily antiretroviral pill to protect men who have sex with men from infection.

MHRP provides prevention, care and treatment through the President's Emergency Plan For AIDS Relief (PEPFAR), but its primary focus is developing a globally effective HIV vaccine.

In September 2009, a six-year clinical trial involving more than 16,000 mostly heterosexual adults in Thailand showed a vaccine candidate to be safe and to have a modest 31 percent effective rate in preventing HIV infection.

It was the first time scientists received a positive signal in any HIV vaccine trial, but 31 percent is not effective enough to distribute the vaccine widely.

Several hundred investigators from around the world, Michael said, are involved in the effort to discover why the vaccine worked and how to improve it. Researchers will then work to create new vaccines for southern Africa based on the HIV viruses that circulate there, he added.

A military scientist researches the HIV virus. (Photo provided by MHRP)

Clinical research conducted at six sites in the United States, Africa and Asia is a key component of MHRP's global vaccine research strategy. For more than 10 years, the Walter Reed Project has worked at the U.S. Army Medical Research Unit-Kenya in Nairobi to help accelerate HIV research, prevention, care and treatment efforts in that nation.

Dr. Frederick Sawe, a Kenyan physician who leads HIV research, said he and his colleagues are working with the Army and through PEPFAR to find better technologies for HIV prevention and treatment.

"Yes we've had success," Michael said, "but HIV is still a world-wide killer of unspeakable proportions and it's time for us to rededicate ourselves to getting the job done and finishing this beast off." (American Forces Press Service)

DoD system tracks diseases around the world

by Cheryl Pellerin

A new Defense Department agency employs combined medical expertise to track health, illness and injury across the military services, said COL Robert F. DeFraites, head of the Maryland-based American Forces Health Surveillance Center.

"The mission is to be the strategic-level public health surveillance agency for the Department of Defense, almost … a very small version of the U.S. Centers for Disease Control for the DoD," DeFraites said.

Divisions

The center does its work through three divisions, including Data and Analysis and Global Emerging Infections Surveillance and Response Systems Operations, called GEIS operations.

The Army Medical Surveillance Activity, for many years recognized as the DoD center for deployment surveillance, became the heart of the new center's data and analysis division, DeFraites said.

"A doctor or nurse might monitor a patient by taking a temperature and vital signs. In public health we do the same thing but for people in a community," he said.

Such public health surveillance involves accumulating statistics on rates of illnesses and injuries across a population, monitoring the trends and taking the information to those who can act on it if necessary.

The division operates the following systems:

— The Defense Medical Surveillance System, a growing database of health-related information on service members collected from the time they enter military service until they are no longer eligible for care.

— The Defense Medical Epidemiology Database, which gives users around the world access to anonymous data from the Defense Medical Surveillance System.

— The DoD Serum Repository, established in 1989 for routine HIV testing, is the world's largest serum repository with nearly 50 million specimens from 11 million people.

Global reach

GEIS is a $50-million-a-year program that coordinates projects in 80 countries and has more than 500 collection sites. GEIS has partner laboratories in North and South America, Asia, Africa, Europe and Australia.

"Our key partners internationally are the overseas Army and Navy laboratories," DeFraites said, including the U.S. Army Medical Research Unit in Kenya, the Naval Medical Research Unit 3 in Cairo, Egypt, and the U.S. Army Public Heath Command branch in Landstuhl, Germany.

Two GEIS-funded laboratories in the United States identified the first four cases of pandemic flu in 2009 and reported them to CDC. GEIS labs conducted global emerging infection surveillance and response efforts with 39 partners in 111 countries.

Build local capacity

In each country an important role for the labs is to build the capacity of laboratories and technicians to monitor, detect and report to the World Health Organization outbreaks of diseases like flu that could affect people around the world.

The International Health Regulations, revised in 2005 and in effect in 2007, help guide the work of capacity building to allow countries to meet their obligations under the regulations, said Navy Captain Kevin Russell, director of GEIS operations. The regulations describe the roles of each country's government agencies, including military agencies, to participate in public health surveillance and outbreak response.

"It's a very dynamic time right now in global biosurveillance," Russell said.

Because national government military and civilian surveillance programs are expanding, from the CDC's Global Disease Detection program to the Defense Threat Reduction Program and others, "there are a lot of challenges for all of us in how to work together," he said.

Future

The future role of GEIS, Russell added, should be to concentrate on the military-to-military piece of disease surveillance and capacity building. A recent meeting on emerging infectious diseases and the role of militaries under the International Health Regulations, hosted by the American Forces Health Surveillance Center in St. Petersburg, Russia, drew representatives from the medical departments of 43 different militaries throughout the world, Russell said.

"We need to continue working with militaries throughout the world, doing capacity building, sample collection, laboratory processing with them more and more," Russell said, "as the Department of State and other agencies work with the civilian sector." (American Forces Press Service)

CAPSULES

Fort Sam Houston

A crew filmed two scenes of the upcoming movie "Battleship" at the Center for the Intrepid. The first scene featured actress Brooklyn Decker as a physical therapist and COL Greg Gadson, director of the Army Wounded Warrior Program, as a rehabilitating warrior. Another scene was filmed in the computer-assisted rehabilitation environment (CAREN), which uses a treadmill and dome to simulate scenes rehabilitation patients can walk through. Some 55 patients and staff served as extras for the filming. COL Jennifer Menetrez and CPT Terrance Fee gave technical advice.

Fort Knox

Jordan Dental Clinic has reopened after renovation that included adding digital X-ray equipment and the CEREC machine, which maps a tooth with a computer and makes a crown in 10 minutes.

"We got all brand new equipment, chairs, operatory and systems," said SFC Sidney Robinette.

Iraq

Soldiers with U.S. Division-Center taught about 20 Iraqi nurses and midwives neonatal resuscitation techniques during a two-day class in Al Anbar.

"Iraq has a high birth rate, but also a high infant mortality rate, and this training will help," said LTC Vincent Barnhart, 1st Armored Division Surgeon, who served as lead instructor.

Fort Lee

Patients of Kenner Army Health Clinic now call a new patient appointment center to schedule an appointment or obtain other military health-care information, replacing the previous TRICARE appointment line.

"Moving patient scheduling in-house means more control of our available appointments and far fewer instances of not filling an opening or double-booking a slot," said Scott Norris, chief of clinical operations.

'It will eliminate the frustrating business of calling around to various phone numbers to find an appointment," Norris added.

Washington

More than 60 volunteers helped 127 sick and terminally-ill children fly to Santa's workshop at the North Pole, courtesy of United Airlines. After a short flight, the group landed at a redecorated gate area and were greeted by cartoon characters, puppets, clowns and carolers. Among the volunteers were 25 members of the Office of The Surgeon General, as well as staffers from Walter Reed Army Medical Center, DeWitt Army Community Hospital, PEO Soldier and the Marine Corps Chemical Biological Incident Reaction Force.

Bavaria

Bavaria MEDDAC has entered into a partnership with the neighboring town of Edelsfeld, Germany. Leaders expect the result will be better understanding of both cultures.

Fort Hood

The Fort Hood, Texas, warrior transition brigade received MEDCOM's retention award for reenlisting and returning to duty more than 49 warriors in transition.

Korea

The 8th Army command surgeon office supplied a 17-foot Christmas tree at Dragon Hill Lodge on Yongsan Garrsion, Korea, decorating it with red, white and blue ribbons, yellow ribbons, purple ribbons and commanders' coins from around the Department of Defense. The Army logo topped the "Army Strong" tree.

Fort Stewart

Soldiers from the 53rd Infantry Brigade Combat Team, Florida Army National Guard, underwent a Periodic Health Assessment during demobilization at Fort Stewart, Ga. Typically, the PHA is conducted at a unit's home station.

"Providing the PHA during demobilization process could save time and resources, and allow for a more medically-ready National Guard force," said COL Paul Cordts, commander of Fort Stewart MEDDAC.

Fort Riley

The Disability Evaluation System of Fort Riley, Kan., MEDDAC has been recognized for integrating Department of Defense and Department of Veterans Affairs processes. The time for completing the process has improved from 540 days to 231 days. Notably, the process integrates warrior transition battalion providers and nurse case managers, DoD military providers and VA providers and social workers under one umbrella called the WTB/MEB clinic, so the process is more transparent for Soldiers.

Short Shots

SSG Bryan H. McVeay is NCO of the Year and **PFC Eva Vazquez-Zuniga** is Soldier of the Year at **Fort Campbell DENTAC**...**SGT Raymond Stanford** and **SPC Rusty Farias** are **Public Health Command's** Best Warriors.

SPC Andre Daniel is Soldier of the Year and **SSG Devon Poole** is NCO of the Year at **Walter Reed Army Medical Center**…**SSG George L. Foster** and **SSG Scott N. Schumacher** of **Walter Reed Army Medical Center** and **MSG Deonn R. Cannon** and **1SG Luis A. Natal** of **Public Health Command** were inducted into the Sergeant Audie Murphy Club.

Fort Belvoir MEDDAC and **Fort Benning MEDDAC** won their respective installations' flag football championships…**LTC Muriel Brown** of the **AMEDD Center and School** and her son Frankie Jr. were members of the United States team competing in the World Karate and Kickboxing Association championships in Edinburgh, Scotland. Brown earned a bronze medal in karate weapons while her son earned a silver medal in sparring and bronze in team forms.

Among awards presented at the Joint Forces Pharmacy Seminar were Army Junior Pharmacy Officer of the Year to **CPT Walter Unruh** of **Fort Knox MEDDAC**, and Mel Liter Clinical Pharmacy Award to **Dr. Rania Kattura** of **Darnall Army Medical Center.** Darnall's pharmacy department also was recognized for efforts to limit medication-related adverse events.

Seventeen wounded warriors from **Fort Bragg** swam with sharks as well as other sea creatures at the Georgia Aquarium in Atlanta. The tank, size of a football field, contained two whale sharks, as well as nurse and hammerhead sharks and a variety of fish and rays. The exercise allowed the warriors to test their abilities.

TRICARE communication programs raked in awards in 2010. The TRICARE Overseas Contract communication campaign won a gold award from the League of American Communications Professionals in the Magellan Award community relations category. The anti-smoking Website, www.ucanquit2.org, received the Aesculapius Award of Excellence from the Health Improvement Institute, the MarCom Gold Award for Best Website, and the Platinum Award for Best Overall Internet Site from eHealthCare.

Brian C. Zeichner, an entomologist for **Public Health Command**, received a regional Excellence in Technology Transfer award from the Federal Laboratory Consortium for Technology Transfer...**Susan Smit**h of **Public Health Command-Europe** has qualified to be named a certified manger of quality/organizational excellence by the American Society for Quality.

Upcoming Events

March 1: 124th anniversary of the Enlisted Corps

March 3: 100th anniversary of the Dental Corps

March 18-25: Armed Forces Public Health Conference, Hampton, Va. Information: https://usaphcapps.amedd.army.mil/afphc/ Contact AFPHC@amedd.army.mil

May 16-21: Warrior Games for wounded, ill and injured service members, Colorado City, Colo. Events will include shooting, swimming, archery, track and field, cycling, sitting volleyball and wheelchair basketball. Apply through chain of command.

May 30: Memorial Day

June 3: 95th anniversary of the Veterinary Corps

June 14: Army Birthday/Flag Day

June 27-30: AUSA/MEDCOM Symposium, San Antonio, Texas

July 4: Independence Day

July 27: 236th anniversary of the Medical Corps and Army Medicine

Desert Storm freed Kuwait 20 years ago

by Sanders Marble

On Saddam Hussein's orders, Iraqi forces invaded Kuwait on Aug. 2, 1990. On Aug. 8, the first U.S. Soldiers landed in Saudi Arabia, at first to defend America's long-time ally as Operation Desert Shield. When months of diplomacy failed, the operation shifted to liberating Kuwait by force, Operation Desert Storm.

The first AMEDD Soldiers deployed with the first lift of the 82nd Airborne Division, but the Armed Forces Medical Intelligence Center already had information on endemic diseases. In the next two months, XVIII Airborne Corps deployed two light and two heavy divisions, an armored cavalry regiment, and support troops — more than 120,000 Soldiers, plus troops from the other services and coalition allies.

More troops

One corps could defend Saudi Arabia, but more troops were needed to liberate Kuwait. VII Corps deployed from Europe, bringing more medical units — one MEDEVAC unit even flew from Germany. Reservists were mobilized, starting two weeks after American troops arrived in Saudi Arabia, both deploying and back-filling TDA hospitals. Reserve mobilization stepped up in January 1992 when President George H.W. Bush authorized the call-up of up to one million National Guardsmen and Reservists for up to two years. Ultimately just over half the AMEDD soldiers deployed to the Gulf were reservists.

The medical support was robust for several reasons. Since Iraq could mobilize over 1 million soldiers, a large friendly force was needed. Army doctrine was designed for fighting the Soviet Union, a 'World War III' that would have generated many casualties. And Iraq was known to have weapons of mass destruction, which could generate large numbers of casualties; some predictions were for 2,000 per day.

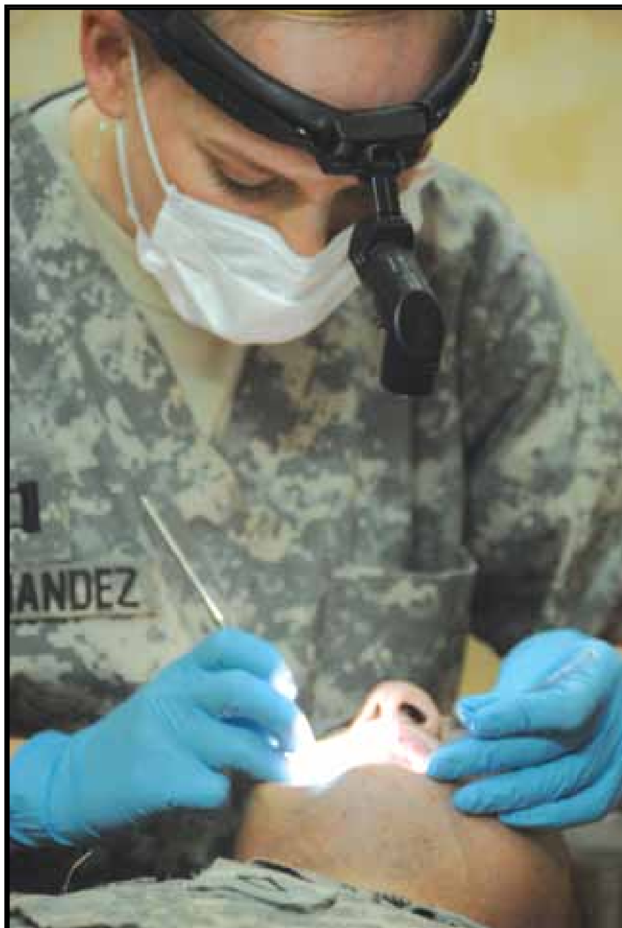
Thus 196 Army medical units, with more than 50,000 Soldiers, deployed. This included 44 hospitals with almost 9,500 beds from all components. The Navy and Air Force had more beds, and Saudi Arabia provided 9,000 beds that were staffed with American personnel. In addition, there were 5,500 beds staffed in Europe, and military and VA hospitals in the US were preparing for casualties. While preparing to fight a major war, the AMEDD still had to care for dependents and retirees.

Air, artillery, and missile attacks started on Jan. 17, 1991, and the ground assault on Feb. 24. The ground campaign would only last 100 hours, ending at 0801 Feb. 28. American forces had only 467 wounded, and 293 dead; almost half the fatalities were non-battle.

Lingering hazards

Redeployment began on March 17, but much medical work remained to be done. Due to concerns about Iraqi chemical and biological weapons, drugs and vaccines were fielded although they were still being tested, and the services had trouble documenting what was administered to whom. There were also questions about environmental hazards to which personnel were exposed — ranging from air pollution to depleted uranium — which were poorly documented. When service members began reporting a range of symptoms, there was no way to know what they had experienced. These issues led to development of post-deployment health assessments.

The large deployment also led to changes. If patients could be flown back to the U.S., it would allow a far smaller footprint in theater. This was a joint concern, since the Air Force would have to fly the patients, and was addressed with new technology (such as the Life Support for Trauma and Transport litter that is close to a portable intensive-care bed) and new units, such as the Air Force's critical care air transport team. Hospitals, even MASHs, had mobility problems in the Gulf, adding impetus to developing toward surgical teams. Other systems were also changed in the continuing effort to prevent injury and disease, and provide the best medical care in harsh environments. (Office of Medical History)



CPT Bonny Hernandez, with Charlie Company, 115th Battalion, 1st Brigade Combat Team, 1st Cavalry Division, from Fort Hood, Texas, does dental work on a Soldier at Joint Security Station War Eagle, near Baghdad, Iraq. (Photo by SSG Tyrone Clakely/Joint Combat Camera Center Iraq)

Army Dental Corps will celebrate centennial next month

This March the Dental Corps will celebrate 100 years of service. DC officers, active and retired, and other members of the Army Dental Care System will gather in San Antonio for an Army-sponsored Centennial Continuing Education event that will feature renowned current and former Army guest speakers. The Association of Army Dentistry, the Dental Corps' newly established "alumni association", is also sponsoring a formal Centennial Birthday Ball celebration and other festive events.

From the Revolutionary War until the late 1800s, Soldiers with dental emergencies were the responsibility of Army physicians. Then in 1901, civilian dental associations successfully lobbied for legislation requiring that the Army employ 30 contract Dental Surgeons.

For the next 10 years the contractors proved the value of their service and gained the trust of the Surgeons General. Even so, it again took a public law in 1911 to force the Army to grant commissioned officer status and another five years (1916) for a Congressional mandate to provide some equality with the Medical Corps for rank, pay, and benefits.

World War II dental clinic of the 2nd Field Hospital at Woodstock, Australia, in 1943. (File photo)

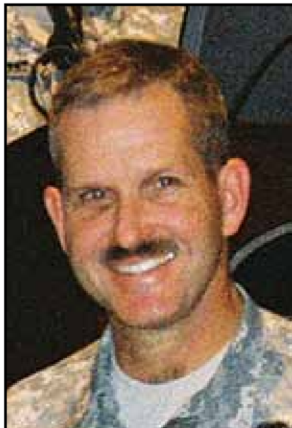
Please read our article in the March issue of the Mercury for more history of the Dental Corps. (Office of Medical History)

Outstanding physicians earn top honors

by Jerry Harben

Army Surgeon General LTG Eric B. Schoomaker honored three Medical Corps officers with 2010 Physician Recognition Awards and an outstanding physician/educator with The Surgeon General's Award for Military Academic Excellence (the Lewis Aspey Mologne Award).

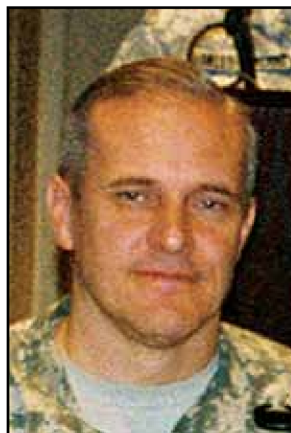
COL James R. Ficke, chair of the department of orthopedics and rehabilitation at Brooke Army Medical Center, Fort Sam Houston, Texas, received the Mologne Award. He established an integrated Army/Air Force orthopedic department for the San Antonio Military Medical Center, and the San Antonio Uniformed Health Education Consortium's orthopedic surgery residency program, which has had the highest in-service resident test scores for three years. He also worked with Medical Research and Materiel Command to establish an orthopedic extremity trauma research program.


COL James Ficke

Ficke co-chaired four national symposia highlighting the orthopedic injury burden on society, current scientific knowledge gaps and research advances in the field. He has led the Center for the Intrepid to international renown as an injury rehabilitation facility, and fully developed traumatic brain injury treatment and education programs.

Receiving The Surgeon General's Physician Recognition Awards were LTC Romney C. Andersen, MAJ Matthew W. Short and CPT Julie A. Hundertmark.

Andersen is chief of the integrated orthopedic service at Walter Reed Army Medical Center in Washington, D.C., and the National Naval Medical Center at Bethesda, Md. He has personally staffed or operated on more than a thousand injured service members. In the past year, the orthopedic service produced more than 100 publications and presentations, received more than $1 million in research grants, and achieved a 100 percent first-time pass rate on graduates' board-certification examinations.


LTC Romney Andersen

While deployed, Andersen served as theater consultant for orthopedics and chief of orthopedics at a combat support hospital in Iraq.

Short is director of the transitional year program at Madigan Army Medical Center, Joint Base Lewis-McChord, Wash. He has received the Residents' Choice Award and the BG George J. Brown Mentor's Cube for his work with Madigan's graduate medical education programs. He implemented colonoscopy training in the Family medicine residency, and has created a Family medicine endoscopy fellowship program that will begin training physicians next year.

MAJ Matthew Short

Short created Madigan's objective structured clinical examination (OSCE) with multiple physician educators, and coordinated with the University of Washington to write a book on how to perform the OSCE and use the examination results to improve program performance.

Hundertmark is a family medicine physician at Fort Benning, Ga., MEDDAC, and is officer in charge of one of the Army's first fully-operational Patient and Family-Centered Medical Home programs. She developed four practice-based care teams to ensure assigned patients receive coordinated continuity of care, resulting in patients being seen by a provider from their team at least 90 percent of the time. She also implemented an advanced access appointing system to ensure an appointment is available within 24 hours of a patient's call. Visits to urgent-care clinics outside the military treatment facility have decreased from 530 a month to fewer than 80 a month, and visits to the hospital emergency department also have decreased.

CPT Julie Hundertmark

Before this assignment, Hundertmark served 12 months in Iraq as a battalion surgeon with the 215th Brigade Support Battalion.

Family Association honors flight medic's Family

Story and photo by Rob McIlvaine

SGT Joseph Campbell left his flight medic duties with C Company, 1st-214th Aviation Regiment in Afghanistan and joined his Family in Landstuhl, Germany, where they hosted charity events all day. The next day they got up at 6:30 a.m. for a plane ride to the U.S. to receive the Army Family of the Year award.

The Campbells received the award from the National Military Family Association at a luncheon in Arlington, Va.

"Sergeant Campbell is a great representative of Army Families and the spirit of Army Families," said Army Chief of Staff GEN George Casey Jr..

"This is not my award. It's my wife's and my daughters' award," Campbell said.

While Campbell was deployed to Afghanistan, his second tour of duty downrange, his Family kept busy by managing three successful charities: Operation Angel, Project Portrait, and Project Rudolph, which all seek to help deployed or injured service members and their Families with specialized care packages, hospital visits and photo projects.

"Let me tell you about this woman," said Joseph. "When I was getting ready to go on a mission back in 1997, Tawny sold my CDs and used the money to buy gifts for a needy Family."

"On Valentine's Day, she made cookies for an old folks' home. And I thought, 'Well, maybe it's just a phase.' That was so many years ago and that phase is still going," Joe said.

"I can't stand next to this woman without feeling somewhat humbled by her service," Joe said.

One Family from each of the uniformed services were recognized.

The Mullin Family from Randolph Air Force Base, Texas, was chosen as Military Family of the Year.

"We didn't care if we won this Military Family of the Year award, because the biggest prize we won was having Joe come home. Nothing can compare to that," Tawny said.

All seven Families received an all-expense-paid trip to Washington, D.C., for about a week.

The association recognizes strong military Families who embrace their service to the nation, are role models in their community, and understand that together they are stronger.

The Campbells believe in the importance of Family.

"There's a lot of interaction between all of us. That's the way we roll," Tawny said, laughing as she and her 7-year-old daughter looked at each other.

"What's the most important thing?" Tawny asked Ceilidha, who didn't hesitate for a moment.

"Family and love," Ceilidha said. (Army News Service)

SGT Joseph Campbell greets Army Chief of Staff GEN George Casey Jr. (far right). Tawny Campbell holds Rhynli, 2, while Celidha, 7, looks on.

Healthy teeth are key part of healthy body

by BethAnn Cameron

Dental health is a key element of health. The health of one's mouth impacts overall health and readiness. February, which is National Children's Dental Health Month, is a good time to refresh basic knowledge of dental health and hygiene.

Which one of the actions below is the most important method for preventing tooth decay?

Limiting sugary snacks and sweetened drinks
Brushing and flossing
Daily use of fluoride toothpaste
Drinking fluoridated water
Chewing sugarless gum
Visiting the dentist at least once a year

All of these measures help prevent tooth decay. Research has shown that brushing with fluoride toothpaste at least twice a day and drinking fluoridated water are the most important. Flossing prevents gingivitis (gum disease), which causes redness and bleeding around the teeth. Chewing sugarless gum made with the natural sugar zylitol blocks bacteria from producing the acids that cause tooth decay. A dentist can check for early signs of decay. Early tooth decay can be reversed if the teeth are treated with fluoride before the decay sets in too deeply.

Which of these actions are important in preventing gum disease?

Seeing a dentist regularly
Regular brushing and flossing of teeth
Avoiding between-meal snacks and sweetened drinks
Using fluoride toothpaste or fluoride mouthwash
Drinking water with fluoride from early childhood

Regular brushing and flossing is important to remove harmful bacteria from the mouth. Seeing a dentist regularly to check the health of your gums so that gum disease can be detected and treated before it causes damage is important. Research has shown these are both key measures in preventing gum disease.

Which of the following best describes the purpose of dental sealants?

To prevent gum disease
To prevent tooth decay
To hold dentures in place
To fill cavities
To improve appearance of teeth

Dental sealants are thin, plastic coatings applied to the grooves and pits on the chewing surfaces of teeth to seal out decay. Dental experts regard placing dental sealants and avoiding between meal snacks as key measures in preventing tooth decay. Dental sealants are commonly placed on the gums of children to prevent tooth decay.

Tooth decay is the most common chronic disease of childhood. It is almost entirely preventable. Children should use a small-headed toothbrush that fits the size of their mouth. Children ages 2 to 6 years should use a small amount of fluoride toothpaste, the size of a pea, on their toothbrush. Children under age 2 should not use fluoride toothpaste unless it is approved by a dentist or health-care provider. Parents should supervise their child's toothbrushing until age 6 to ensure that they don't eat the toothpaste or use too much.

Other dental-health measures that impact health involve sports and deployment. A key prevention measure is to use a mouth guard to prevent dental injuries when playing sports. In addition to football and Rugby, blows to the mouth during activities like baseball, gymnastics, volleyball, skateboarding, soccer, field hockey, rollerblading or bicycling can result in cuts to the inside of the lips (from the edges of the teeth), tooth nerve damage, breakage or tooth loss. Using a mouth guard that fits snugly and adapts to the teeth will help prevent these injuries.

Soldiers who deploy to the field have a higher risk of decay due to the increased amounts of sugars and starches in rations. They should brush at least twice a day with fluoride toothpaste. One can brush without running water by applying toothpaste to a dry brush. Brush all surfaces of the teeth. Spit out the excess toothpaste. Do not rinse after brushing so that the fluoride will stay on longer and protect the surfaces of your teeth. Wait for least 30 minutes after brushing to eat or drink.

We know that tooth decay and gum disease are caused by factors such as diet, hygiene habits and exposure to fluoride. It is important to maintain good dental health to prevent tooth decay and gum disease. Maintain regular tooth brushing and flossing. Have a dental check up ever year. For more information, contact your dental clinic. (Public Health Command (Provisional))

Third-party collections fund medical requirements

by Tim Bowles

If you have received medical care at a military treatment facility (MTF) and not been asked if you have other health insurance, chances are you are either on active duty or someone was not doing their job.

While the question may seem bizarre, this simple question led to a previous fiscal year collection of nearly $100,000,000, directly reimbursed to Army MTFs through the efforts of the Third Party Collections Program (TPCP).

In order to avoid confusion, it is important to make the distinction between TPCP claims and Medical Affirmative Claims (MAC). Like the TPCP, the MAC program can collect funds from third-party payers for the reasonable charges of medical services provided to all covered beneficiaries authorized and eligible for treatment in an MTF; but unlike the TPCP, MAC includes active duty members.

The goal with MAC is not to bill your other health insurance (OHI). It seeks recovery from a third party when tort liability exists. For example, say you were seen at an MTF because of a car accident caused by Sid Sivilain. Since Mr. Sivilain is at fault for your injuries and the subsequent care you received at the MTF, the government has the right to recover associated expenses from him or his automobile insurer.

Conversely, the TPCP seeks reimbursement for all non-tort-related health care from insurance companies. For example, SGM Minor retired and went to work for the city of Sam Lombego. The city of Sam Lombego provides free medical coverage through Inhumana Insurance Co. to all its employees. Even though the retired SGM has free medical care (as a retiree) and gets all his medical care at the Fort Anywhere MTF, the Army will bill Inhumana for the health care the retired SGM received at the Fort Anywhere MTF. This costs the retired SGM nothing and results in big bucks for the Army.

So, why does the government pursue third-party payers? Basically, Congress gave us the authority to do so, partially to recover some of the cost of rising medical expenses.

Many may wonder, "Where exactly does this money go?" TPCP recoveries are deposited into the operations and maintenance (O&M) account of the MTF that provided the care. These O&M funds are used to enhance medical care in ways such as purchasing equipment, furniture, and televisions.

Beside federal law (10 U.S.C. § 1095, codified at 32 C.F.R. § 220), it is important for MTF commanders to pursue payment on third party-claims because it falls in line with the Army Medicine Mission Statement:

To Promote, Sustain, and Enhance Soldier Health

To Train, Develop, and Equip a Medical Force that Supports Full Spectrum Operations

Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes

The process of collecting from your OHI is not something new to your MTF. Since 1986, Congress authorized the collection from third-party payers. However, the Army MTFs did not actively pursue third-party collection (TPC) until 1991 with the forceful implementation of the TPCP. Currently, processing of TPC generally occurs in the MTFs Uniform Business Office (UBO).

The UBO prepares the medical bills and submits the claim to the third-party payer for reimbursement. In addition, the UBO analyzes payments to ensure claims are paid according to plan provisions and dispute denials that may result in the payer wrongfully withholding payment to the MTF.

Once the MTF UBO has exhausted its efforts, the incorrectly processed claims are referred to the MEDCOM UBO for validation of dispute reasons. Upon validation, the disputed claims are forwarded to the MEDCOM office of the staff judge advocate which provides guidance and legal support to the TPCP by pursuing collection of claims inappropriately paid or denied by third-party payers. If an impasse still exists after all arguments have been exhausted, then properly documented disputed claims are referred to the Department of Justice which pursues litigation on the third-party payer that continues to incorrectly reduce payment or fully deny payment to the Army MTF.

The TPCP begins with you. You can help by completing your Record of Other Health Insurance (DD Form 2569) on an annual basis or when your health insurance coverage changes. You can complete this online by going to www.forms.gov and search DD 2569 or by direct link (http://www.forms.gov/bgfPortal/docDetails.do?dId=11369). Bring your completed OHI form the next time you go to an MTF.

Remember, when you are asked in a clinic if you have any other health insurance, you are answering a very important question; the type of question that brings millions of dollars back into the MTF which are then able to continue to provide you with world-class health care. (MEDCOM office of the staff judge advocate)

Army desegregated during Korean War

by Andy Watson

In many ways the Korean War serves as a foundation for Army transformation. One of the largest changes during this time was desegregation of the armed forces. President Harry Truman's Executive Order 9981 on July 26, 1948, signaled the end to segregation as official U.S. Army policy. Unfortunately compliance throughout the Army would take another six years.

The order stipulated equal treatment and opportunity for all within the armed services without regard to race, color, religion, or national origin. These changes followed World War II, at a time when the Army was dealing with numerous issues such as occupation in Europe and Asia, an unprecedented draw-down, and the ever-increasing Cold War.

Before the Korean War, experiences for African-American Soldiers within the medical field were generally not positive. Utilization during World War II was limited and often not well-received. Most units were attached to separate segregated commands such as the 92nd Infantry Division. There was also a hospital completely staffed with African-American doctors and nurses, but it was sequestered at Fort Huachuca, Ariz. With the separation came disparity.

After World War II many medical professionals of all races left Army service. Timing for the loss proved ill-fated as events in Korea soon unfolded.

Early service for African-American medical Soldiers in the Korean War mirrored World War II, as the 24th Infantry Regiment and other segregated units fought against the North Korean offensive. Despite the adversity, African-American medical personnel served in front-line units and provided care and medical evacuation in increasing numbers; however, inequality still loomed over operations.

Some units, such as the 567th Medical Ambulance Company, consisted of predominately African-American personnel, and were attached to MASH (Mobile Army Surgical Hospital) units. In other instances, people with urgently needed skills, particularly nurses, were placed directly into hospital units. While small-scale integration took place, a major shift occurred when GEN Matthew Ridgeway, commander of United Nations Forces in Korea, requested an end of segregation of Soldiers in his command in April 1951.

Early in the war, CPL Levi Jackson Jr., a medic serving with the segregated 24th Infantry Regiment, provided first aid and shielded the wounded while under constant hostile fire near Haman, Korea on August 13, 1950. Mortally wounded during the action, Jackson was posthumously awarded the Distinguished Service Cross.

Members of the 567th Medical Ambulance Company load a wounded Soldier onto a train for evacuation. (File photo from Office of Medical History)

Near the close of the war another African-American medic, CPL Charles L. Johnson, was serving with the desegregated 14th Infantry Regiment during the assault against "Carson Outpost". On May 29, 1953, near Sanae-dong Korea, Johnson provided care to the assault force's wounded and continued supporting the troops even after being blinded during numerous mortar attacks. Johnson was mortally wounded and also received the Distinguished Service Cross posthumously.

Both medics served bravely and without regard to their own safety, but there is a major difference. In the time between the battles the Army had changed. The U.S. Army in Korea was an integrated force. Did the separation or integration of forces affect the medics' decision to put their lives in further danger? No, they were committed to their fellow Soldiers despite any perceived differences, but after desegregation they were able to demonstrate their courage and medical skill within a larger and more inclusive Army. (Office of Medical History)

Assistant surgeon first to earn Medal of Honor

by Lewis Barger

This month marks the 150th anniversary of the Bascom Affair, a small engagement in southeastern Arizona largely forgotten by most Americans today, but which sparked 25 years of warfare with the Chiricahua Apache that ended only after Geronimo's surrender. The Bascom Affair also involved the first heroic act for which a Medal of Honor was awarded — to an Army assistant surgeon.

The Bascom Affair began with the theft of some livestock and abduction of a young boy from John Ward's ranch, most likely by Coyotero Apache. Ward believed the culprit to be Cochise of the Chiracahua and reported the theft to the Army.

2LT George N. Bascom was dispatched with about 60 men to Apache Pass with orders to compel Cochise to return the boy and stolen livestock.

The fresh water spring at Apache Pass made it an important point for overland travel. Cochise and his tribe made their home in the surrounding area and reportedly had good relations with the employees of the Butterfield Overland Mail Company who operated a nearby station for three years, sharing the spring with the Chiricahua. When Bascom and his party arrived they stopped north of the Butterfield station not far from the Chiricahua encampment.

Cochise, accompanied by family members, approached Bascom's camp on February 4, 1861, unaware that the troops had come looking for him.

Cochise entered the tent to talk and Bascom confronted him about the missing livestock and boy, telling Cochise that he and his party would be held as hostages until they were returned. Cochise cut his way out through the tent wall and escaped without injury through a fusillade of bullets. The Soldiers captured the remainder of the party, clubbing and bayoneting one of the Apaches who attempted to follow Cochise.

Following the commotion, Bascom marched his command back to the Butterfield mail station, but Cochise had gathered a party of warriors and reached the station first, capturing one employee and wounding another. Bascom's party arrived during the fight and killed a third Butterfield employee, mistaking him for an Apache. Cochise withdrew, taking the first employee with him as a captive. Bascom dispatched messengers requesting reinforcements and medical support. During the following days Cochise attacked two parties traveling through the pass, killing eight and taking two more people prisoner.

Assistant Surgeon Bernard J. D. Irwin

The first relief column was led by Assistant Surgeon Bernard J.D. Irwin commanding a party of 14 Soldiers. Along the way Irwin and his troops captured three Apache warriors and 10 cattle while covering 100 miles in two days in heavy snow. Cochise saw Irwin's party approaching and withdrew from the area.

Irwin was credited with the relief of Bascom's besieged troopers in addition to the Indians he had captured en route and in 1894 he was awarded the Medal of Honor, making it the first action for which the Medal of Honor was awarded.

Shortly after Irwin's party reached the pass two companies of dragoons arrived, completing the reinforcement of Bascom's expedition. They soon discovered the mutilated bodies of Cochise's three prisoners. In retaliation, the Soldiers hanged the three Apaches captured by Bascom as well as the three captured by Irwin.

Cochise was enraged by the execution of his family members and declared war on the United States.

The Bascom Affair was over, but its repercussions would be felt for the next quarter century. (Office of Medical History)

New bird flies

An HH-60M MEDEVAC helicopter of C Company, 3rd-126th Aviation Regiment hovers before launching a mission from Camp Taji, Iraq. The Vermont Army National Guard unit is the first to receive the Army's newest MEDEVAC helicopter.

"It's like going from a '67 Buick to jumping into a new Cadillac," said SGT David Diminico, an HH-60M crewmember.

The chopper features include an integrated EKG machine, an oxygen generator, electronically controlled litters, an infrared system that can locate patients by their body heat and a built-in external hoist.

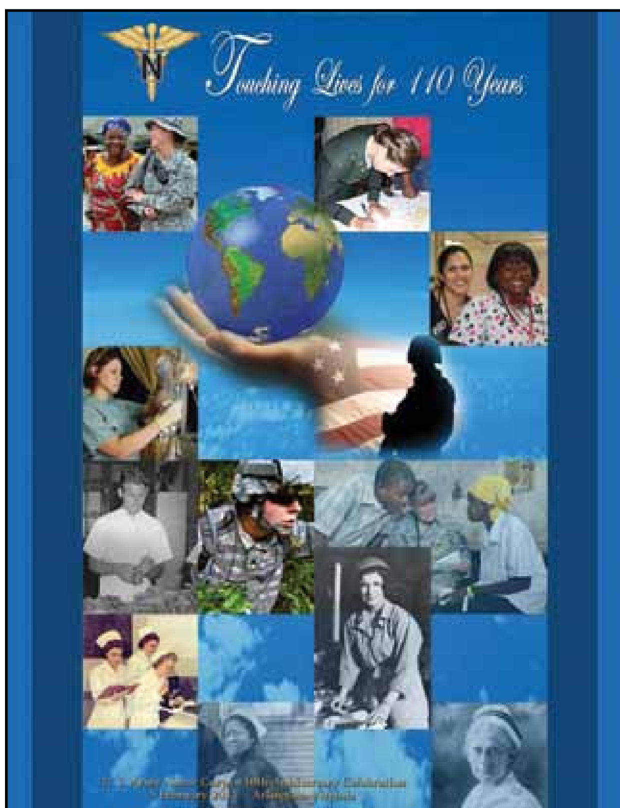
The upgraded derivative of the UH-60M Black Hawk features more powerful engines, improved rotor blades, electronic instrumentation, digital displays and an autopilot feature. The crew chief's seats have moved to the back of the aircraft, making room for up to six litter patients as well as equipment. (Photo by SPC Roland Hale/Combat Aviation Brigade, 1st Infantry Division)

Nurses celebrate 110 years of service as AMEDD Corps

The Army Nurse Corps celebrated the 110th anniversary of its inception on Feb. 2, 2011 … a milestone for the corps, and another chapter for its rich history. Army nurses have stood shoulder to shoulder with Soldiers since 1901, providing care not only to Soldiers, sailors, airmen, Marines and Coastguardsmen, serving and retired, but also to their Families. Army nurses have touched the lives of many throughout their history, and so it was fitting that the theme for this year's anniversary celebration was "Touching Lives for 110 Years" epitomizing the work of Army nurses.

"This theme really resonated with me, it is the essence of what Army nurses do, and have done each and every day" said MG Patricia D. Horoho, deputy surgeon general and chief of the Army Nurse Corps.

Today, more than 9,000 Army nurses serve all over the globe on active duty, in the U.S. Army Reserve, or in the National Guard. They support military and humanitarian missions in support of the war fighter and Army Medicine.



Art created by Heidi Pampel.

The Army Nurse Corps is capitalizing on its legacy built over the years and continues to leverage lessons from the past to ground, gauge, and guide Army Nursing for the future. Horoho developed a four-year campaign plan, as well as a 15-year strategic blueprint. Horoho has four strategic imperatives that include Leader Development, Warrior Care, Evidence Based Management, and Human Capitol. She believes that at the heart of Army nursing is a triad which is comprised of active duty, National Guard, reserve and civilian registered nurses, licensed practical nurses, medics and nursing assistants.

Culture of Trust

Horoho is transforming the corps to ensure The Surgeon General's Culture of Trust. In that regard, under her guidance and direction, the Army Nursing System of Care (ANSOC) was designed to provide the framework to ensure that the same standard of health-care delivery exists in every military treatment facility across the Army. No longer will patients have to navigate the health-care system wondering if the care they received at one medical treatment facility was better than another because it was different. Patients experience health-care processes that are the same whether they receive the care at Eisenhower, Walter Reed, or Madigan Army Medical Center, for example.

Initially piloted at Blanchfield Army Community Hospital at Fort Campbell, Ky., the ANSOC is being rolled out at Madigan, Brooke and Womack Army Medical Centers and will be implemented across all Army facilities over the next 12 months.

Driving change

At a time when the entire nation is debating health-care reform, Horoho believes that the Army Nurse Corps has the opportunity to drive change and support not only Army Medicine but the profession of nursing. The ANSOC is a key enabler for The Surgeon General's Culture of Trust.

Army nursing continues to embrace the past, engage the present and envision the future in support of Army Medicine. (ANC)

ANC honors two officers for excellence

by Jerry Harben

The Army Nurse Corps recognized two of its outstanding junior officers with its Award of Excellence for 2010. The recipient for the Active Army Component is CPT Betty Moore, a staff nurse in the med/psych pediatrics section at Walter Reed Army Medical Center, Washington, D.C. The Reserve Component recipient is 1LT Michelle Imlay of Landstuhl Regional Medical Center, Germany.

Instructor

Moore volunteered many hours to provide formal instruction on nursing ethos to more than 100 nursing staff members. She facilitated a morale improvement event for a patient diagnosed with cancer, which received nation-wide positive media coverage.

While deployed to Iraq, Moore functioned as a subject matter expert for pediatric patient care delivery on her unit, and also as a trainer and instructor for more than 30 local national health-care providers.

Evacuations

Imlay was mobilized last year from 7236th Medical Support Unit at Fort Bragg, N.C., to Landstuhl, where she worked in the 35-bed multi-specialty medical surgical unit. She helped streamline many air-evacuation processes and increased throughput of patients from all overseas contingency operations. Her role was instrumental in opening an additional 20-bed contingency unit while air transport in Europe was interrupted due to volcanic eruptions in Iceland. Committed to leading by example, Imlay also has coached and mentored 37 staff members and ROTC cadets.

The Army Nurse Corps Award of Excellence was established in 1992 with the goal of promoting junior officer leader development. This annual award provides recognition to junior officers who have made significant contributions to the mission of the uniformed services.

Women's heart risk underestimated

by Sharon Renee Taylor

More women should be screened for heart disease, according to MAJ Todd C. Villines, assistant chief of cardiology at Walter Reed Army Medical Center in Washington, D.C.

"We're not screening for the most prevalent cause of death, we're screening for everything else," Villines said.

The cardiologist said women aren't the low-risk population for heart disease they were once thought to be. According to Villines, the focus should be on prevention.

Heart disease is the number one cause of death for American women, according to the most recent statistics provided by the Centers for Disease Control and Prevention. In numbers from 2006, heart disease edged out cancer as the top killer. Health Data Interactive reports show more women died from heart attacks than breast cancer in 2007.

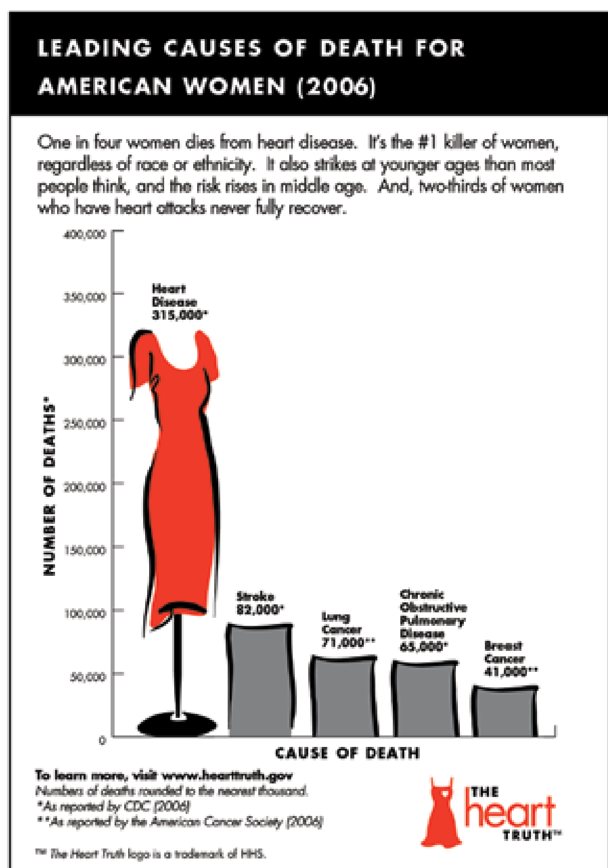
Screening

Villines said women should get a one-time screening test for early heart or vascular disease at age 55, just as they seek other preventive exams.

"Just as we promote prevention in women using serial mammograms and pap smears," the cardiologist said the same should be done for heart disease. "I don't think a one-time screening test for early heart disease in a man at age 45, and a woman at age 55, is a big stretch."

In their 2010 update of heart disease and stroke statistics, the American Heart Association reported an estimated 81 million American adults, more than one in three, have one or more types of cardiovascular disease. More than 42 million women currently live with some form of cardiovascular disease, and more than 8 million women have a history of heart attack.

Crushing chest pain is often attributed as a sign of heart attack, but some symptoms may be more subtle than others, according to Villines, an associate professor of medicine at the Uniformed Services University of the Health Sciences in Bethesda, Md.



February is American Heart Month

"People think of an elephant standing on their chest and severe chest pain, but not all patients have that. Some have shortness of breath or other less severe symptoms they attribute to other things, and unfortunately, don't seek medical attention." Villines said.

For women, symptoms of a heart attack may be shortness of breath or pain in the back, neck or throat. Unfortunately, this results in a higher rate of missed heart attacks for women, the cardiologist said. He explained the same can happen with men, but historically percentages for women are much higher.

High blood pressure, high blood cholesterol, smoking, diabetes, a Family history of early heart disease, age, being overweight and physically inactive are all risk factors for heart disease, according to the National Institutes of Health. An annual trip to your primary-care physician is a good place to start to identify risks.

"Hypertension is the most common risk factor for women and men who have heart attacks, stroke and heart failure," Villines said.

Risk factors

Someone can exercise, eat right, sleep, maintain a balanced life and still have high blood pressure or high cholesterol, the cardiologist said. While smoking, diet and exercise can each be modified to reduce the risk for heart disease, other risk factors, like high blood pressure and high cholesterol, can be inherited.

Race may also play a role. In its Heart Truth action plan for African American Women, the National Institute of Health stated the risk of heart disease is more prevalent in black women than white women — as are some of the factors that increase the risk of developing it, including high blood pressure, overweight, obesity and diabetes.

The risk for heart disease increases for all people with parents or siblings who were diagnosed with heart disease before age 55 for men and age 65 for women.

The American Heart Association said smokers' risk of developing coronary heart disease is two to four times that of nonsmokers, calling it a "powerful independent risk factor for sudden cardiac death in patients with coronary heart disease; smokers have about twice the risk of nonsmokers."

Despite reporting a slight, non-significant decline in cigarette smoking among service members, a 2008 Department of Defense survey of health-related behaviors among active duty military personnel reported smoking was higher among service members deployed to operational theater than those who were not deployed.

"I know when I was deployed it seemed like everyone was smoking over there," said Villines, who deployed in 2007 with the 399th Combat Support Hospital as the theater cardiologist in Iraq. He believes smoking among young Soldiers has increased and fears that many don't realize the long-term consequences if they continue to smoke.

"We put [coronary artery] stents in a couple of 29-year-old kids. I think they were both smokers...they were otherwise healthy Soldiers," Villines said. "They had no idea that they had any cardiovascular disease."

The first place to go if they have risk factors is their primary-care physician, who will look at the whole patient, including exercise and diet, make an intervention and then follow-up for the results, Villines said. He describes the Army's move to annual Periodic Health Assessments as a positive change.

Yearly assessment

Nearly two years ago the Army began conducting PHA, a yearly assessment that provides Soldiers, commanders and providers with a better understanding of a Soldier's readiness, deployability and health status.

PHAs replaced the Periodic Physical Examinations. Five-year physical exams and over-40 physical exams are no longer conducted. The assessment reviews Family history, blood pressure and cholesterol for each Soldier regardless of age.

Patients with possible symptoms of cardiovascular disease are often referred by their primary-care physician for non-invasive tests like cardiac CT (computed tomography) angiography, which provides direct views of the coronary arteries to see if there's a blockage or early coronary plaque build-up, explained Villines.

"We're able to give people not only the diagnosis, but their prognosis," the cardiologist said. "Even when there is not a blocked heart artery, we're now able to diagnose heart disease at a very early stage to hopefully make important changes to prevent future heart problems. hat's something that we're real excited about."

"We put [coronary artery] stents in a couple of 29-year-old kids. I think they were both smokers...they were otherwise healthy Soldiers. They had no idea that they had any cardiovascular disease."
— MAJ Todd C. Villines

The hospital also provides coronary artery calcium screening and carotid intima-media thickness test (CIMT), both non-invasive screening tests for early cardiovascular disease in asymptomatic patients.

"Getting people to adopt a healthy lifestyle — weight loss, diet, smoking cessation, regular exercise — that's the cornerstone for prevention," Villines said. "If you do medicines in the absence of those things, you're only getting a fraction of the benefit." (Walter Reed Stripe)

USASOC Medic of Year died in action

by Tracy Anne Bailey

"Fully knowing the hazards of my chosen profession," is a phrase from the Ranger Creed — one that SGT Jonathan K. Peney, 22, lived and died by as a Ranger combat medic.

"Sergeant Peney was a devoted and extraordinary Ranger medic," said CPT Andrew Fisher, 1st Battalion, 75th Ranger Regiment physician assistant. "He possessed all of the talents and maturity necessary to excel both personally and professsionally in any organization."

Peney, who was assigned to Company D, 1st Battalion, 75th Ranger Regiment at Hunter Army Airfield, Ga., was on his fourth combat rotation as the company medic when he was killed by enemy forces.

Honors

For his actions on and off the battlefield, Peney was posthumously named the 2010 U.S. Army Special Operations Command Medic of the Year and the Special Operations Medical Association Medic of the Year.

"Intrinsically motivated, Sergeant Peney captivated the medical staff's attention as one to watch for positions of greater responsibility," said Fisher. "He was always searching for ways to increase his understanding of medicine and ultimately provide better care for his patients."

When Peney's company deployed ahead of the battalion, he volunteered to deploy with them. He had just nine days to recover after graduating from the grueling Ranger School, and left his new bride of just a few months.

"Sergeant Peney could not stay back and watch his platoon deploy to a combat zone without him," said Fisher. "This is a testament to his selfless service."

While on his final deployment in support of the war on terror, Peney reacted and treated casualties from two separate enemy engagements.

The first engagement was a complex attack at an airfield in Afghanistan. A Soldier stepped on a land mine and Peney applied a tourniquet and stopped the bleeding before directing the Soldier's evacuation to a higher level of medical care.

SGT Jonathan Peney

In the second engagement, without regard to his own safety, Peney reacted to an effective enemy indirect fire outside of his barracks area. With his medic aid bag hung over his shoulder, he was the first to respond to the scene and immediately identified and triaged five international workers wounded in the attack.

Triage

"Sergeant Peney immediately conducted casualty triage and determined the most critical patient to be a man with an amputated leg," said Fisher. "In addition to stabilizing this patient, Sergeant Peney directed the other medics on the scene to stabilize their patients and move them inside to the casualty collection point that he had established."

Like the seasoned combat veteran and medic that he was, Peney took charge and controlled the chaos in the room.

"He issued calm and clear directives to three medics, a physician assistant and a physician," said Fisher. "He triaged and organized the evacuation of all the patients based on their priority. All of the patients lived as a result of Sergeant Peney's courage under indirect fire, his responsiveness and his expert application of trauma management."

Peney's last full measure of devotion was given on June 1 in Kandahar Province, Afghanistan.

His platoon had successfully conducted a search and attack operation a couple of days earlier and secured a strongpoint for the day. Shortly after sunrise, the enemy attacked the strongpoint from three directions with an intense barrage of small arms, rocket-propelled grenades and sniper fire.

During the initial volley, a team leader sustained two gunshot wounds and was critically wounded.

"Without hesitation and with complete disregard for his own personal safety, Sergeant Peney ran through effective automatic weapons fire to get to his wounded Ranger," said Fisher. "He was killed by enemy fire while moving under heavy fire to provide aid to the Ranger."

Example

"Sergeant Peney was a fine example of what we expect a Ranger Medic to be," said Fisher. "He not only challenged himself every day, but also his peers and the medical providers. I will miss his constant asking of medical questions, for which he had no shortage."

Peney's mother, Sue Peney, and his wife Kristin Peney, accepted the awards.

"Jon was always very compassionate and curious from the start of his life to the end of his life," said Sue Peney. "He loved being a Ranger Medic. He knew what had to be done. I know in spirit he stands by his wife and me, and most importantly the men he loved in his unit." (75th Ranger Regiment)

For non-extremity wounds

New bleeding simulator will improve training

Story and photo by Sarah Maxwell

Medical simulation technologies are being developed to give medics and combat lifesavers more realistic training that could result in lives saved on the battlefield.

The Army Research, Development and Engineering Command's Simulation and Training Technology Center showcased multiple prototype technologies at the world's largest modeling, simulation and training conference held in Orlando, Fla.

One of those promising training tools is the HemSim, which is a training simulator to teach medical Soldiers how to stop hemorrhages in wounds where tourniquets can't be used, said Dr. Teresita Sotomayor, science and technology manager at STTC's medical simulation technologies program.

Tourniquet training has been an integral part of basic Soldier lifesaving skills by preventing or stopping hemorrhaging, or excess bleeding, which many times prevents death. But tourniquets can only be applied to wounds on legs and arms, she said.

"Now we need to focus on non-extremity wounds," she added.

Sotomayer, along with the help of a private industry partner and Soldiers' input, is developing a capability to simulate body wounds as well as the hemostatic, or blood clotting, agents medics use on the battlefield.

The HemSim, if fully researched, developed and employed, will be a valuable simulation tool available for medic warriors to practice on before heading to the battlefield. Its realistic looking wounds will have the ability to be worn by a person or a dummy and would simulate the hemorrhage bleeding medics need to know how to stop.

"I would love something like this," said SFC Jennifer Jordan, a medical trainer from Fort Indiantown Gap, Pa., whose expertise is being harnessed to help guide the project in the right direction.

As an educator for Soldiers with no medical training all the way to the highly skilled combat medic, she said this type of simulation could benefit all of their preparation to employ their skills in a combat situation.

"We try to make the (medical training) dynamic — we want them stressed," said Jordan. "Any emotional response we can elicit from students — they'll remember it better."

She and her students' input helped take the realism of the simulation to another level with the ability to actually warm the fake blood used in the prototype, which allows the medics in training to make that "emotional" connection to real blood, said Jordan.

Not only is the prospect of using such advanced training tools to teach with exciting for Jordan, but so is the ability to actually be able to give input for something that could really make a difference down the road.

"The relationship we have with RDECOM is brilliant," said Jordan. "They want feedback and are taking it from all levels."

"It will allow us to give a better product to our students to make a difference where it matters — not just for students but for the guy who's out there bleeding," she added. (Army Research Laboratory)

SFC Jennifer Jordan demonstrates the HemSim medical simulation prototype for teaching hemorrhage control.