NAVY MEDICAL CORPS NEWS

From your Medical Corps Chief, CAPT Paul Pearigen:

First, let me welcome you to the new year as your Corps Chief. I hope 2016 will prove safe, prosperous, and professionally satisfying for you and for those you hold close. I am honored to have taken the reins from VADM Bono as your 12th Chief of the Medical Corps, and I thank her, the M00C1 team, and your Specialty Leaders for the progress in advancing the Navy's physician corps during Admiral Bono's tenure. I know we are all grateful that she has been promoted to the position of Director of the Defense Health Agency and are proud of having one of our own in such a challenging, but critical, role at this stage of the Military Health System's history.

Having been named Medical Corps Chief by the Surgeon General in mid-December, I am still within my "first 90 days" in the role. My assessment and initial conversations across the Corps are ongoing as I work with you to develop, and refine, our focus for the coming months and years. For instance, earlier in January I had the privilege of speaking to our aeromedical community at the U.S. Naval Aeromedical Conference in Pensacola, as well as visiting with Medical Corps officers at Naval Hospital Pensacola. It was a great opportunity to be among just a few of the many segments of our exceptionally professional, deeply knowledgeable, and undeniably dedicated physician colleagues. I look forward to getting out there to see you in groups small and large to listen and to learn, which I consider crucial to my ability to lead.

This is a very active time in healthcare in the United States, and no less so in the Military Health System and in Navy Medicine. Where there is challenge, there is also opportunity. I expect our Navy Medical Corps to embrace this time, leading from a place of strength among our clinical, operational, and educational teams—not just willing to consider innovations, but indeed driving those innovations as we bring forth the breadth of experience, background, skills, and even generations found within our number. If we don't lead and drive the effort toward solutions and

WINTER 2016

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From the Corps Chief (cont.)

patient-centered outcomes, not only will those solutions be lacking, but we will be less relevant and will have no right to complain or object when the solutions don't meet our physician ethos. What's more, if we don't actively participate and lead in this setting, we will have individually and collectively fallen short on what is inherent in being a professional.

"Where there is challenge, there is opportunity"

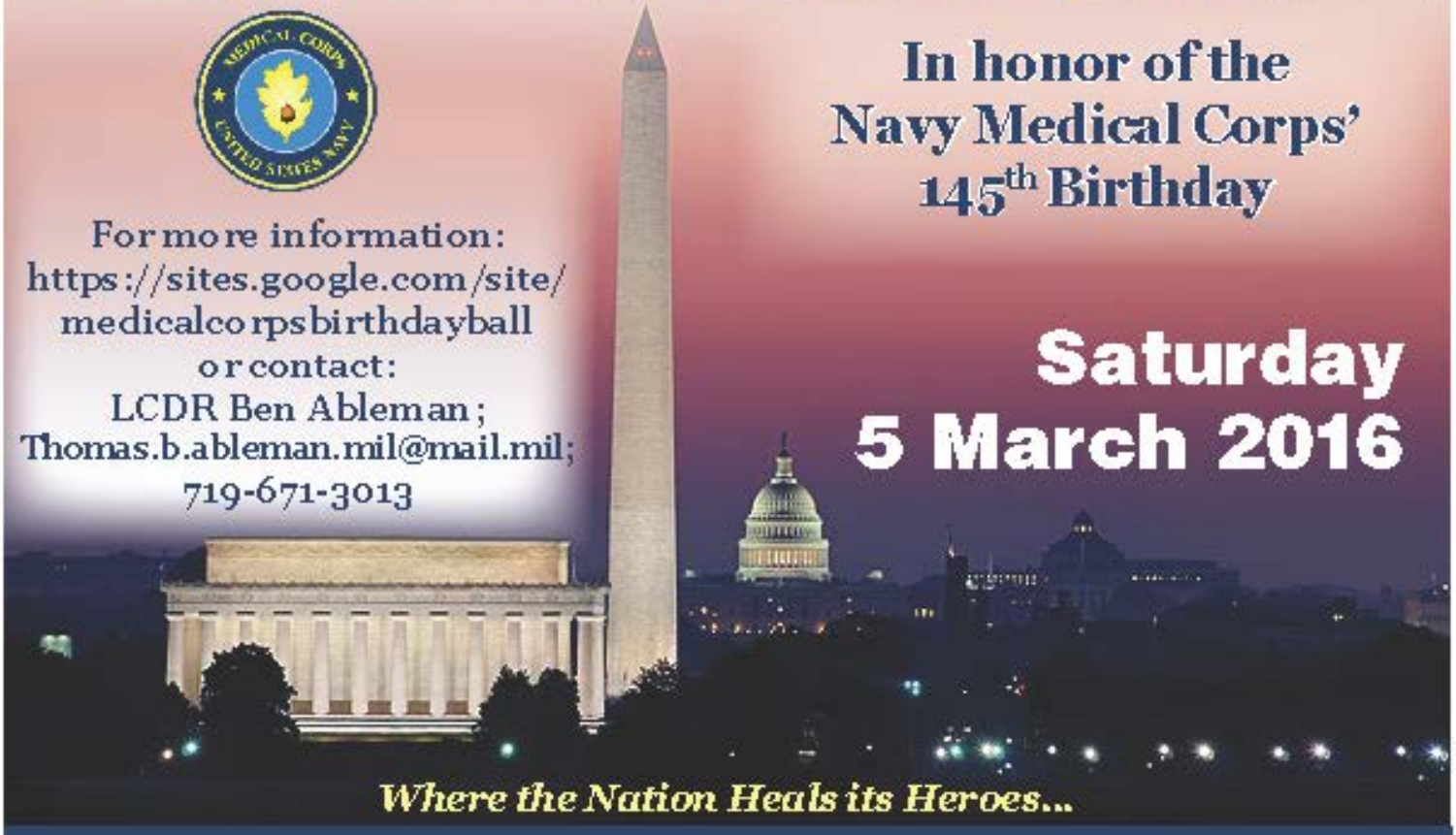
The quality of your service, as you experience it, underpins the quality of our Service. My job is to mentor, encourage, enable, and celebrate you—regardless of rank, specialty, longevity, or background—in this time of great challenge and great need. In the coming months, I'll have more to say about such pressing issues as currency and competency, skills sustainment, career management, physician leadership, high reliability, talent management initiatives, transitioning of additional operational billets to board-certified providers (i.e., "GMO conversion"), and others. For now, I congratulate those who have recently been named to CO or XO positions, as well as those heading for senior operational and executive medicine roles. I also congratulate and deeply thank those who have turned over the Specialty Leader mantle in this past year. Your example of personal and professional excellence has advanced our Corps and the Navy's healthcare team.

Over the years, I have had the privilege of working with, deploying with, and learning from many of you. For those who don't know me—very briefly, I am an emergency physician with a subspecialty in medical toxicology; I trained in Philadelphia and San Francisco in civilian programs on a deferment in those early years of EM when Navy was growing its cadre—but only had two spots per year in what was then our only inservice residency (which obviously wasn't going to grow the community very fast!). I spent my early years of active duty in graduate medical education as faculty, residency director and ultimately in the institution-wide role we now call DPE/DIO. In more recent years, two WESTPACs as CATF and then ESG Surgeon/FST OIC, MTF DH, a BUMED tour as SG's EA, MEDCEN Deputy Commander, CO of Naval Hospital Camp Pendleton, Surface Forces TYCOM Surgeon, and Naval Inspector General have given me an opportunity to travel to many places and settings around the globe where the people of Navy Medicine—and our Medical Corps—are caring for Sailors, Marines, families, and those who have served before us, advancing force health protection, providing the readiness required by COCOMs, and engaging in global health and medical research. I welcome your input and involvement in our shared calling as physicians and Naval Officers, and I look forward to serving you and our Navy/Marine Corps team as your Corps Chief. PDP

Call for Spring issue articles

Please send Medical Corps Newsletter article ideas and submissions to CAPT Greg Thier: gregory.t.thier.mil@mail.mil

NATIONAL CAPITAL AREA
MEDICAL CORPS BIRTHDAY BALL



In honor of the
Navy Medical Corps'
145th Birthday

For more information:
https://sites.google.com/site/medicalcorpsbirthdayball
or contact:
LCDR Ben Ableman;
Thomas.b.ableman.mil@mail.mil;
719-671-3013

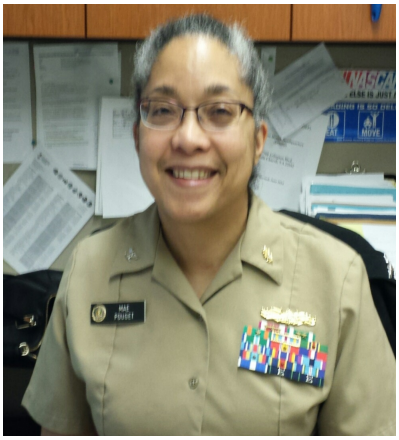
Saturday
5 March 2016

Where the Nation Heals its Heroes...

Cost: $100

From the Deputy Corps Chief

CAPT Mae Pouget



A bullet calls attention to a particular passage. A bullet is a missile, a projectile that damages by piercing, a very fast and accurately thrown, or hit, object. So…how do you express information when you write a FITREP or EVAL bullet? Do you concisely detail the cause and effect of your actions as they relate to Navy Medicine? Is your verbal "weapon" a Daisy or a Glock 45 with hollow points; are you shooting blanks or a 50-cal? Do your activities support the goals of your community, Command, and the Surgeon General? Will the information you are firing at your reader make them pause and take notice?

"The board is selecting future Navy Medicine leaders, make it easy for your presenter(s)"

You are writing for at least two audiences, your command leadership and the promotion board. Your chain-of-command and the board members have been where you are. They understand FITREPs and EVALs. They understand the "kiss good-bye," "soft break-out" and "forced distribution." The board members are aware of the ranking reputation of your chain of command. They know who typically writes recommendation letters and who does not. They also recognize mixed messages from your chain-of-command, when the number ranking does not match block #41. The board is selecting future Navy Medicine leaders, make it easy for your presenter(s); clarify your accomplishments and your potential for greatness in your community.

When you sit down to write for promotion, do so with the understanding, others are describing similar events. You are in competition with everyone in consideration for the next rank. Keep in mind what makes you different as you write. Draft your initial FITREP or EVAL, then put it aside. Review and rewrite it several times before forwarding it to a mentor, friend, or supervisor for review and recommendations. Elucidate to the board why they should recommend you for promotion, why it is imperative for you to be promoted. Make yourself stand out, go for the 50-cal.

Career Planner Words

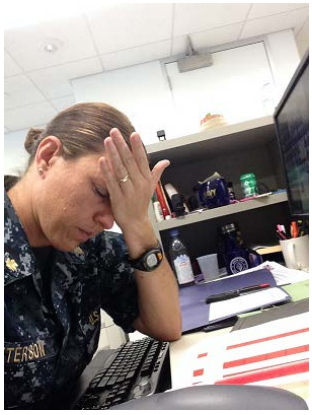
The generational shift of Navy personnel to Millennials poses a new set of challenges for both the Navy and Navy Medicine to attract and retain the best and brightest individuals in the service of our nation. Within the Department of Defense, the Department of the Navy, and key leadership within the organization are talent management initiatives to drive the force of the future. The concept of Talent Management, conceived in ca. 1997 by McKinsey, became a priority throughout the Department of Defense in 2014 and was the subject of the Chief of Naval Operations Strategic Studies Group 34. In fact, Secretary Mabus has said: "To fight and win, we need a force that draws from the broadest talent pools, values health and fitness, attracts and retains innovative thinkers, provides flexible career paths, and prioritizes merit over tenure." Furthermore, Defense Secretary Ash Carter has said that his Force of the Future program is necessary to ensure the Department of Defense continues to attract the best people America has to offer. Some of the initial rollouts of his initiatives are: defense digital service, blended military retirement system, shifting between AD and reserve service, increased opportunities for AD to spend time in industry or graduate school and return to the military with that knowledge.

In alignment with the Department of Defense, Navy Medicine also MUST align itself to current realities with respect to Talent Management in order to recruit, development, promote, pay, and retain the best and brightest of the Medical Corps. The Surgeon General Assessment cell (SGAC III) is the Surgeon General's think tank, which brought together, over the preceding year, subject matter experts to analyze the current Navy Medicine Talent Management strategies to recruit, train, and maintain a thriving and prolific Medical Corps which leads the Military Health System and National Healthcare, in general.

Additionally, Navy Medicine Professional Development Command, in conjunction with the Navy War College, has identified the necessity to improve our leadership development strategy relative to the Medical Corps. Career planners of all Corps within BUMED have consulted with the Commanding Officer of NMPDC to make the following recommendations: 1) **POM for funding increase seat availability at Leadership courses**, 2)**Create pathways for HCA/MBA/ECL pursuit nonclinical fellowship FTOS via GMESB**, 3)**increase use of virtual mechanisms to expand attendance at learning institutions**, 4) **improve Formal Mentorship programs**, 5) consider **incorporating 360-degree review**, and 6) **developing robust and Improved Career Development Board process for MC officers**.

Both the SGAC and Leadership Development working groups are promising initiatives to value the Medical Corps. Inherent in this valuation, is improving physician resiliency. Current statistics suggest that over 40% of physicians experience burnout. As physicians, we face competing demands to see a certain number of patients in a day, keep up with technology, meet record-keeping rules, and align with the military mission which often make it difficult to build interpersonal relationships with patients or with colleagues. There is too little time and too little opportunity for developing those bonds. However, these bonds are critical to ensure caregivers have the resilience to move past loss, improve care and avoid burnout. Enhancing physician engagement requires a multistep process that includes making an effort to better understand the physician's world; encouraging opportunities for input and participation in care redesign; providing education, training, guidance, and support; and making the effort to recognize and thank them for what they do. The aforementioned initiatives are an essential first step in this process. More is necessary and the Navy is committed towards cultivating our talent as a corps, and ultimately improving physician resiliency and engagement.

CAPT Jamie Oberman



Conference Travel Update

Think you are frustrated with the conference approval process? Try working with it every day for over the last year. That is what the Medical Corps Chief's Office Fellow, LCDR Jami Peterson has been doing - and doing well. Fortunately for us, she now has it down to a science. Below are tips and techniques provided by the good LCDR to ease your own pain - just like a good internist does.

The spring and summer are an exceptionally busy time for conferences. Here are a few reminders to assist you in preparing conference request packages.

PRESENTATIONS: Please include the title of submitted abstracts, lectures or podium presentations. If someone has submitted, but hasn't been accepted yet, please STILL include the title of their submission and include the individuals on your request paperwork. It is easier to remove them if they aren't accepted than it is to add them after the fact.

CME: Have your CME attendees utilize the fill-in-the-blank example provided.
__X___ State license requires _#__ category 1 CMEs every _#__years to maintain licensure/board certification. Attendee currently has __#__ category I CMEs for this gathering cycle which ends in 20##_. ie "CA state license requires 30 category I CME every 2 years, attendee has 15 category 1 CMEs for gathering cycle ending in 2015 . Attendee has not beento a funded CME conference in over 2 years."

COMMITTEE/BOARD MEMBER: Please include the name of the Committee/Board meeting an individual will be attending.

Always download the conference request forms off the website.

If you designate a quota manager to complete the conference request packet paperwork make sure they are aware of what needs to be included or have them call me prior to starting and I will walk them through the main items.

The DNS and DoNAA are developing a new set of conference travel guidelines specific to the Navy. That guidance will be more reflective of the new 2015 DoD Conference Travel Guidance released in September 2015. If SECNAV approves that document, it will be the guidance we follow. However, until SECNAV that happens, it is business as usual.

Email completed conference request packets and general questions to:
usn.ncr.bumedfchva.mbx.bumed-conference-approval@mail.mil

Do not hesitate to call or email me with any questions or concerns.

LCDR Jami J. Peterson

Plans & Policy Update

Happy New Year, Navy Medical Corps! With the start of a New Year, we close out on something that has been in the works for several years – BUMED reinvention. The entire intent of BUMED reinvention was to streamline the authorization process thus speeding up the time to decision. This included creating "Supercodes" and coalescing multiple codes into them. This allows for decisions that can be handled at a lower level (than the Surgeon General or the Deputy Surgeon General) which should speed things up. As I mentioned, we are closing out this chapter here at BUMED and the term "Reinvention" no longer applies. We are now fully into implementation mode. That doesn't mean there aren't additional growing pains or hiccups along the way but I do believe improvements are here.

A crucial piece to maintaining our readiness in both wartime skils as well as at the MTFs is ensuring our clinical skills are maintained. This is a top priority at BUMED and is being looked at with a multi-faceted lens. In the Corps Chief's office, we are embarking on a CNA (Center for Naval Analysis) study to look at determining if there are actually objective ways of measuring clinical skills. Without hard data, it is more difficult to establish true requirements for maintaining skills. Within this study, we are hoping to learn what the true influence is of skills erosion while in operational, non-clinical, or low-volume assignments. As the study begins, you may be asked to participate with surveys and/or interviews. Please participate as time allows to help us answer what we feel are important concerns.

I'm happy to report that milSuite continues to grow and is being used and seen by hundreds of Medical Corps officers on a regular basis (average of 200/day!). Many more Specialty Leaders are developing their own pages and have been populating them with specialty-specific content. Before you embark on a google search for Navy Medical Corps career information, please take a look at the official Navy Medical Corps milSuite page to see if you can get your question answered at our one-stop shop.

Click HERE to check out milSuite or go to: https://www.milsuite.mil/book/community/spaces/navy-medicine/navy-medical-corps

If you feel that there is a BUMED instruction that needs updating, please contact CAPT Thier at gregory.t.thier.mil@mail.mil to discuss

Medical Corps Reserve

Navy Medical Corps Reservist wins Emmy

Yes, you read that correctly. We know that we have a lot of talent in the Navy Medical Corps, but this officer literally takes the trophy.

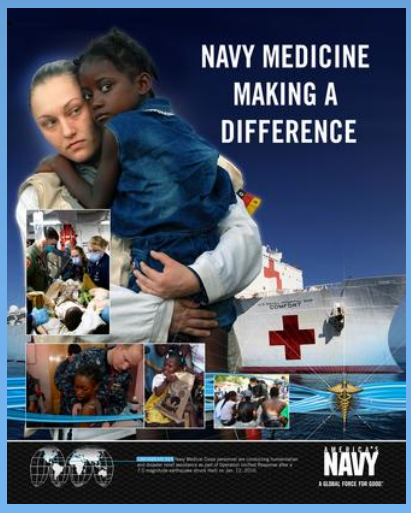
Mark Brady, MD, MPH, MMS, DTM&H is an emergency physician based out of Memphis, TN. The grandson of WWII veterans in the Seabees and Navy, he restarted the family tradition of naval service; his father served in the Army in Vietnam and his older brother is a Blackhawk pilot for the National Guard. Brady has a medical degree and a master's degree in biomechanical engineering from Brown, a master's in public health from Harvard, a diploma in tropical medicine and hygiene from the London School of Hygiene and Tropical Medicine, did a fellowship in emerging infectious diseases with the NIH in South America, and did his emergency medicine residency at Yale where he was chief resident. He has done research, worked clinically and taught in Cambodia, South Africa, Liberia, Peru, Bolivia, Spain and Japan.

When not working in various emergency departments or as a faculty member at the University of Tennessee, Brady makes documentaries. His last documentary 24|7|365: The Evolution of Emergency Medicine aired on PBS and won the New England Emmy for Best Documentary. Narrated by Anthony Edwards (Top Gun, ER), this history of Emergency Medicine begins with military trauma care and ends with the modern emergency department. "Emergency Medicine has its roots in military medicine; time-sensitive interventions and systems were largely developed on the battlefield." Brady says that most people are surprised to learn that Emergency Medicine only became a specialty in 1979. "Anyone, anything, anytime- that's our motto. People take it for granted that you can walk into any ER and receive care, but it didn't used to be that way a generation ago." You can see the entire documentary for free online at 247365doc.com, including additional extra segments about things like War and Medicine and Women in Medicine.

2016 MHS Female Physician Leadership Course

The 2016 Female Physician Leadership Course will be held at DHHQ 11-13 April 2016. This year, Navy Medicine provided a phenomenal response to the call for course nominations. The Medical Corps submitted over 45 nominees from 18 different commands with 18 medical specialties represented. A selection board will convene at BUMED the first week in February and select the final attendees and alternates. Selected nominees will be notified no later than 12 February 2016. Thanks again for the amazing show of support for our female physician leaders. Contact LCDR Jami Peterson with any questions or concerns.

O: 703-681-8928
jami.j.peterson.mil@mail.mil



Navy Cardiology Provides Valuable Health Screening during Pacific Partnership 2015

by CDR Dylan Wessman

During Pacific Partnership 2015 (PP15), Navy Cardiology was represented aboard the USNS MERCY (T-AH 19) by general cardiologist, CDR Dylan Wessman, and cardiovascular technician, HM2 Timothy Tamminga. Together, they performed echocardiography-based subject matter expert exchanges in the host nations of Fiji, Papua New Guinea, and Philippines. They observed numerous cases of advanced rheumatic heart disease (RHD) and uncorrected congenital heart disease in very young patients. While in Roxas City, CDR Wessman and HM2 Tamminga partnered with pediatric cardiologists from the Philippine Heart Center to conduct a RHD screening at a local elementary school.

HM2 Tamminga performs screening tests on children at Culasi Elementary School in the Phillippines during PP15.

The cardiology group from the Mercy conduct Rheumatic Heart Disease screenings at the Culasi Elementary School in July, 2015

They also toured both the Philippine Heart Center and the Armed Forces of the Philippines Medical Center in Metro Manila. While in Da Nang, Vietnam, they were joined by interventional cardiologist, CAPT Keshav Nayak, and pediatric electrophysiologist, LCDR Ben Blevins, for a subject matter expert exchange focused on transcatheter device closure of atrial septal defect and patent ductus arteriosus. The team also saw a dramatic case of ectopia cordis in an infant awaiting surgery at Da Nang General Hospital. Overall, PP15 proved to be a rewarding experience, both professionally and personally, for these Navy cardiologists.

FY-16 CO/XO Selection Results

The process of screening for FY-16 commanding officers and executive officers has resulted in several Medical Corps officers being selected.

Please join us in congratulating the following officers in their achievment:

Commanding Officers

CAPT Bradley Smith - James A. Lovell Federal Health Care Clinic

CAPT James Hancock - NH Camp Lejeune

CAPT Steven Blivin - NH Guam

CAPT Rosemary Malone - NH Yokosuka

CAPT Rees Lee - NMRU, Dayton

CAPT Todd Wagner - NMCPHC

CAPT Mark Goto - NMOTC

CAPT Peter Roberts - USNS Mercy (T-AH 19)

CAPT James Young - Naval Health Clinic Patuxent River

"Leadership is not about being in charge. Leadership is about taking care of those in your charge."

-Simon Sinek

Executive Officers

CAPT Theron Toole - NHC Quantico

CAPT William Todd - NH Jacksonville

CAPT Gregory Thier - NH Lemoore

CAPT Richard Knittig - NH Okinawa

CAPT Robert Jackson - NH Rota

CAPT Andrew Vaughn - NMRU, Cairo

CAPT Carolyn Rice - NMOTC

CAPT Steven Kewish - Role III Kandahar

CAPT Jeffrey Timby - Tripler AMC

CAPT Kathryn Elliott - USNS Comfort (T-AH 20)

What It Takes to Become an Undersea Medical Officer

by CDR James Mucciarone

Each year the Navy trains approximately 24 Undersea Medical Officers (UMO's). The function of the UMO is to ensure medical readiness, and to provide medical care, for the Navy's undersea services, including submarine Sailors and Navy divers. The majority of candidates that enter training are between internship and residency, however, all applicants are considered and the best are selected. Recent trainees include physicians selecting a second tour before applying for residency, a board certified anesthesiologist and a board certified fellow in pulmonary and critical care.

UMO training is divided into 3 phases. Phase one is six weeks at the Naval Undersea Medical Institute (NUMI) located on Naval Submarine Base New London in Groton, Connecticut. Training during this introductory phase includes rigorous physical conditioning and topics from the Submarine Officer's Basic Course. Students will also receive lectures on the operational aspects of medicine, psychiatry, and dentistry. Physical Training is emphasized during this phase to prepare the student for dive school, and entails approximately two hours of swimming, running, calisthenics and water confidence training per day. The goal of the physical training is for the student to pass the diver Physical Standards Test (PST) and to prepare for Diving Medical Officer (DMO) training conducted at the Naval Diving and Salvage Training Center (NDSTC). Students must be able to pass the Diver PST to enter Phase Two.

Phase Two is nine weeks of diving training at NDSTC in Panama City, Florida. An emphasis on physical conditioning is continued with daily exercises conducted by the dive school staff. The first weeks of training incorporate basic and advanced SCUBA diving, to include both pool and open water SCUBA dives. Candidates then receive training in surface supplied (hard hat) diving equipment. Candidates are also introduced to the closed circuit re-breathing systems use by Naval Special Warfare (oxygen based) and the Explosive Ordinance Disposal Teams (mixed gas based). The second phase concludes with experience in hyperbaric chamber operations and extensive training in the Navy Recompression Tables and diving medicine.

Phase three is approximately eight weeks. Students return to NUMI for additional professional development, refresher in general medicine topics and special topics in Naval Special Warfare Medicine, Tropical Medicine, and Clinical Hyperbaric Medicine. To better prepare them for their jobs, during phase three, UMOCs receive extensive training in Radiation Health and health record administration. In addition, students are required to take and pass a comprehensive oral board encompassing all material presented in the course during all three phases of training.

Once training is complete the opportunities are numerous. There are billets with diving commands such as Mobile Diving and Salvage Units ONE and TWO in Hawaii and Virginia, with Naval Special Warfare in California and Virginia, and with the Explosive Ordinance Disposal Units throughout the world. There are billets with the submarine community in Washington, Georgia, and Connecticut. Other

Becoming a UMO (cont)

graduates will go to research billets at the Naval Experimental Diving Unit, the Naval Submarine Medical Research Lab and the Navy Medicine Research Center.

Selection for Undersea Medicine is through the Graduate Medical Education Selection Board process. If you would like further information concerning opportunities in Undersea Medicine please contact the Undersea Medicine Specialty Leader, CAPT Edward Waters (edward.t.waters.mil@mail.mil), the Officer in Charge of the Naval Undersea Medical Institute, CDR James Mucciarone (james.j.mucciarone.mil@mail.mil), or the Undersea Medical Officer Candidate Program Manager, LT Mike Parenteau (michael.a.parenteau4.mil@mail.mil).

News You Can Use

Specialty Leaders

Please join the Chief of the Medical Corps in welcoming several new specialty leaders:

Emergency Med - **CDR Joel Schofer**
Dermatology - **CDR Anis Miladi**
Internal Medicine - **CDR Timothy Quast**
Pulm/Critical Care - **CAPT(s) Joon Yun**
Med Students/HPSP - **LCDR Kendric Aban**
OB/GYN - **CAPT(s) Kristina Morocco**
Psychiatry - **CAPT Jamie Reeves**
Pathology - **CDR Arash Mohtashamian**

Reservists
Plastic Surgery - **CDR Khang Thai**
Dermatology - **CDR Erin Adams**
Radiology - **CAPT Michael Herron**
Ophthalmology - **CAPT Matthew Norman**
Urology - **CAPT Kara Taggart**

MC Standardized CV and Bio templates can now be found on the Navy MC milSuite site. Point your browser HERE

Job Opportunities

Latest billet announcements posted on milSuite:

BUMED -

1)Corps Chief Plans & Policy Officer (O6) - Summer 2016

2) Corps Chief Career Planner (O6) - Summer 2016

3) Director of Surface Medicine (O6) - October 2016

4) Chief Medical Informatics Officer (05/O6) - Summer 2016

Direct all CVs and Bios to CAPT Pouget at:
mae.m.pouget.mil@mail.mil

Perspectives On Leadership by a CP-15 Physician

Staying Clinically Engaged While in Leadership Roles

by CAPT Christine Sears, CO
USNAVSO/ FOURTHFLT Surgeon

A young woman sustains a compound fracture of the tibia in a motor vehicle accident. She waits as an inpatient in the hospital for 2 weeks, hoping a family member can earn the funds to purchase the hardware for surgical repair. She fears that if her leg heals on its own. She will have deformity and disability. Fortunately for her, the USNS COMFORT (T-AH 20) is deployed to the region in support of Continuing Promise 2015, and an international team will provide surgical repair on board, at no cost to her.

After consultation she undergoes an open reduction and internal fixation under regional anesthesia on board COMFORT. Her orthopedic surgeons represent the US Navy and Brazilian Air Force and are assisted by a civilian surgery resident from the host nation. The scrub nurse is Australian, volunteering with Project Hope. The circulating nurse volunteers with Latter Day Saints Charities. Together, this multinational, multi organizational team performs the procedure on the ship in state of the art facilities. She does well postoperatively and returns home in several days.

One of the greatest opportunities in Navy Medicine is the option to practice in a variety of settings. Deployed tertiary care via the sea is an incredible sign of American capability, strength, and hope. Missions like Continuing Promise are unforgettable. As medical professionals, we can reach across barriers based on our professionalism and common understanding of humanity. In a six month period, the Continuing Promise team cared for more than 122 thousand patients and performed more than 1200 surgeries in 11 countries in Central and South America and the Caribbean. In Haiti, we shared in an official international engagement with Cuban physicians, the first such public engagement in many years. My goal here is not to highlight the numbers, but rather to highlight the opportunity Navy Medicine has to offer and encourage you in your career. You've heard some specifics from our pediatrics colleagues in this newsletter already throughout the summer and fall, and I hope hope to provide another, complimentary perspective.

Cpt Cima, a Brazilian orthopedic surgeon, and LCDR Hammond, a US orthopedic surgeon from Naval Medicine Center Portsmouth, mentor young physicians during CP15

As physicians, we have specific skill sets in the international healthcare team. In Central and South American and the Caribbean, physicians are held in high regard, enabling partnership with military and civilian leaders alike. COMFORT's Executive Officer, CAPT Miguel Cubano, and I are both surgeons, general surgery and urology, respectively. Hence we had the opportunity not only to lead but also to operate alongside our US and international colleagues. We were able to engage with our Department of State partners, Non-Governmental Organization Leadership, local and national Ministry of Health officials, and the media. We even had the opportunity to mentor international medical students and young attending physicians in the host nations, often being able to boast about them to their senior colleagues. All these engagements will help strengthen our ties in the region, and should improve our communication during the next humanitarian crisis in the region so that the response can be more efficient and effective.

Physician Leadership Perspectives (cont)

Staying clinically engaged help us truly understand the mission and enabled us to enjoy some of the most rewarding work ever. I was able to utilize my pelvic reconstructive surgery subspecialty alongside the gynecology team of CDR Kerry Hudson and CDR Kevin Byrd from Naval Medical Center Portsmouth in the care of patients with stage 3 and 4 pelvic organ prolapse. I had the opportunity to assist LCDR Howard Pryor , a pediatric surgeon from Walter Reed National Military Medical Center, in repairing a urinary tract disorder in a young girl. Her condition had been present for 4 years, such that she was no longer in the typical age range for the disorder, making the diagnosis more challenging than it would have been in the US. Providing direct clinical care helped me stay focused on what made this mission a once in a lifetime experience for many of us.

The leadership aspects of the mission were truly rewarding. The healthcare team on board comprises both the reduced operating status crew of 58, who are attached permanently on orders, as well as a full operating status team of more than 600 who are assigned temporarily for the mission. The team came together quickly to deliver quality care in challenging environments, with procedures that were aligned with those seen across Navy Medicine in land based facilities. The success we had was certainly due to the amazing Navy physicians and speaks well to their training and dedication. The opportunities in Navy Medicine are incredible- be prepared to take them!

LT Garcia Salas, an internist from Naval Hospital Beaufort, greets the Cuban ambassador to Haiti during a visit to the outpatient medical site in Haiti.

2015 Heroes of Military Medicine Award presented to Navy Medical Corps Officer

CDR Darian Rice, an anesthesiologist and Residency Program Director at Naval Medical Center Portsmouth received the 2015 Hero of Military Medicine Award on May 7, 2015 from the Chief of Naval Operations at the Andrew Mellon Auditorium in Washington, D.C. The Heroes of Military Medicine (HMM) Awards honors outstanding contributions by individuals who have distinguished themselves through excellence and selfless dedication to advancing military medicine and enhancing the lives and health of our nation's wounded, ill and injured service members, veterans, and civilians. The Heroes of Military Medicine was presented by the Center for Public-Private Partnerships (CP3) at the Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc. (HJF). The Offices of the Surgeon General of the Navy nominated CDR Rice for this award and was chosen by the HMM Advisory Committee comprised primarily of former Surgeons General.

Supporting High Reliability Through Simulation

by LCDR Monica Lutgendorf, MFM, NMCSD

Navy Medicine is committed to supporting and developing high reliability practices. To this end, the OB/GYN Department at Naval Medical Center San Diego developed an innovative, high fidelity multidisciplinary simulation exercise focusing on obstetric emergencies and postpartum hemorrhage. This was a true team effort with key leaders from the Department of Obstetrics and Gynecology Maternal Fetal Medicine, Department of Anesthesiology, Department of Pediatrics, Neonatal Intensive Care Unit, Maternal Infant Nursing Department, and Transfusion Services. Due to the important benefits of in situ multidisciplinary simulation exercises, command leadership and patient safety departments were integral partners in the development and execution of this exercise!

The exercise was conducted on Labor and Delivery to allow participants to use real supplies and resources during the exercise. The team trained 113 participants over 2 days, including obstetric providers (staff physicians, midwives and residents), obstetric anesthesia providers (staff anesthesiologists, certified nurse anesthetists, residents and student nurse anesthetists), and labor and delivery nurses. In addition to assessing medical knowledge and technical skills, the simulation was designed to assess and to reinforce teamwork and communication skills, and to identify areas for improvement within our healthcare system. The simulation exercise also provided a unique opportunity to critically evaluate the obstetric massive transfusion protocol with a full blood bank tracer with simulated preparation of a complete massive transfusion pack.

High Reliability (Cont)

Following the simulation, particpants debriefed with their teams allowing teams to forge strong bonds, review strengths and weaknesses and collectively develop process improvement ideas. Multiple process improvement areas were identified during the exercise, which can be addressed and used to improve patient safety.

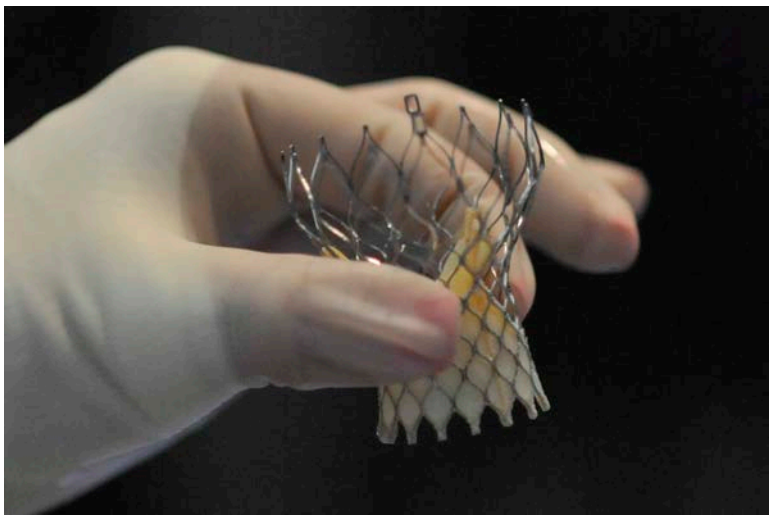
At the completion of the simulation exercise, participants universally felt that the exercise was both helpful and realistic. Participants especially enjoyed the focus on teamwork and enjoyed the opportunity to debrief with constructive criticism.

We plan to continue these important exercises in the future, and want to extend our sincere thanks to the all the participants, simulation facilitators, and leadership that supported this exercise and made it a success. Thank you also to COL Shad Deering, MC USA, from the Uniformed Services University Central Simulation Committee for the Mobile Obstetric Emergencies Simulator program and the Society for Maternal Fetal Medicine's Critical Care Obstetric Course, which inspired this project.

Cutting Edge Cardiology

by CAPT Keshav Nayak, Cardiology, NMCSD

Naval Medical Center San Diego recently launched the transcatheter aortic valve (TAVR) program . Thanks to the great efforts of many individuals on the Heart team and highly supportive Directorate and Executive steering council leadership, a 16-person team of cardiologists and surgeons, nurses, and technologists was able to implant the first ever TAVR at an MTF on March 16th, 2015. This historic first is a testimony to the dedication and commitment of the NMCSD Heart team and NMCSD leadership to adopt and implement the latest technologies for our beneficiaries thereby providing life-saving therapies to non-surgical patients. Since March 2015, the program has completed 20 successful implants without a single death, myocardial infarction, or major stroke—these are phenomenal clinical results in very sick, or extremely high risk valvular heart disease patient population. Since the first cases, the team is now partnered with the San Diego Veteran's Administration Hospital to perform TAVR with a joint Navy-VA team.



For those unfamiliar with this therapy, TAVR is a minimally invasive cardiac surgical procedure that has revolutionized the treatment of aortic stenosis, especially in high risk or nonsurgical candidates. Conventional surgical aortic valve replacement (SAVR) is typically an "open heart" procedure which involves arresting the heart and using cardiopulmonary bypass to support the circulation. The aortic valve is accessed through the chest wall, the diseased valve is surgically removed, and a replacement valve is sewn in its place. The Society for Thoracic Surgeons database indicates a typical operative mortality of 2-4% for this procedure, although the risk can be as low as 1% for low risk patents at high volume centers. TAVR is significantly different from SAVR; a replacement aortic valve is mounted on a catheter, typically introduced via the femoral artery, then advanced through the aorta and implanted inside the diseased native valve via self- or balloon-expansion. The valve is composed of bioprosthetic (xenograft pericardium) leaflets sewn to a highly flexible metal alloy frame. Patients are generally awakened and extubated immediately after the procedure and discharged after 2-4 days. The CoreValve US pivotal TAVR trial demonstrated safety and efficacy for the Corevalve self-expanding prosthesis for patients at high surgical risk and those deemed inoperable for SAVR based on extreme surgical risk. In the high risk cohort, survival with Corevalve was superior to SAVR at one year, and at three years the outcomes remained comparable with that of SAVR. Currently, the Heart team is using the latest generation Corevalve Evolut R which is a repositionable valve with excellent outcomes to include 1 year 93.3% survival, 3.4% CVA, and 15.2% pacemaker implantation rate.

Rollout of this innovative program has conferred many benefits for our patients and the Heart team alike. Prior to offering this therapy at NMCSD, the Heart team would often refer Navy patients to nearby civilian hospitals. Now, patients can avail of this therapy without painstaking transfers, or repeat unnecessary work-ups. Needless to say, our patients much prefer to receive their complex cardiac care by their own Navy physicians at their Navy hospital. As for the Heart team, there is continued enthusiasm by all members of the

Cutting Edge (cont)

TAVR implant team, from echocardiographers to cardiovascular technicians, in being able to participate in this program essentially curing sick patients of their valvular disease without high risk SAVR. One might ask how does having a TAVR program benefit an MTF whose primary mission is to treat the active duty patient. Well, TAVR is ideally suited for wounded warriors who are dependent on assist-devices such as wheelchairs, or amputees who must use their upper-bodies. By using a percutaneous method to fix their valvular disease without open sternotomy, these patients will have the ability to resume full activity far sooner than conventional surgery. Furthermore, valve-in-valve therapy can be used to avoid redo sternotomy in the active duty patient who has a failing bioprosthetic valve.

TAVR represents a paradigm shift in the fields of interventional cardiology and cardiac surgery. Having the opportunity to launch the TAVR program for our patients at NMCSD has been extremely exciting for the entire Heart team. To be the first TAVR DoD MTF program will remain an everlasting memory!! Furthermore, we are proud to offer cutting edge procedural therapy with a combined DoD-VA Heart team for military and VA beneficiaries entrusted to our care.

News From the Detailers

Since the convening of the GMESB we have been working on proposing orders towards this Summer's PCS cycle. Orders are primarily being funded for early Spring timeframe at this time and the general orders precedence as it pertains to funding is as follows:
Highest: Operational/ OCONUS/ no-cost / new accessions
Lower: Residency/Training
Lowest: Shore Tours
Once orders are proposed in the system, they will wait in the queue until it is funded by the budget managers for release in NSIPS. If a Letter of Intent is needed to get on base housing or CDC wait list, we can provide one within a week or two; however, there is no line of accounting attached so they cannot be used to schedule HHG move or any travel. Officers should contact their detailer if they do not have orders 90 days prior to detach or have further questions.

Check your professional record online:
http://www.npc.navy.mil/CareerInfo/Recordsmanagement/

Selection Boards:
http://www.npc.navy.mil/Boards/GeneralBoardInfo/

Request Extension:
http://www.public.navy.mil/bupers-npc/officer/Detailing/rlstaffcorps/medical/Pages/default.aspx

Medical Corps Chief's Office (M00C1)

Mission Statement

To provide support and guidance to active duty and reserve Navy Medical Corps Officers and the commands in which they serve.

Vision Statement

We wish to empower and embolden all medical corps officer to achieve professional and personal excellence.

Guiding Principles

To earn the trust of our MC officers by consistently demonstrating our service, information, value, and innovation.

To recognize the diversity and contribution of our people. We create a work environment that is challenging and provides the opportunities and support for everyone to learn and succeed.

The ultimate outcome of the Corps Chief's Office is the quality of care and the quality of life of Navy Medical Corps officers.

Our office has a culture that encourages, rather than punishes, staff members who identify errors or system breakdowns.

The Medical Corps Chief's office makes decisions based on data, which includes the input and experience of specialty leaders, program directors, leadership at all levels, individual officers, and other subject matter experts.

Specialty Leader vs Detailer: What's the Difference?

by CDR Joel M. Schofer, MD, MBA, CPE, FAAEM, Emergency Medicine Specialty Leader and Recovering Detailer

Many Medical Corps officers don't understand the difference between their Specialty Leader and their Detailer, therefore I'd like to briefly explain the differences between the two.

DIFFERENCE #1 – WHO THEY WORK FOR

A Specialty Leader works for Navy Medicine (BUMED), the Surgeon General, and the Medical Corps Chief. A Detailer works for Navy Personnel Command (NPC or PERS). NPC/PERS is a line command, while BUMED is obviously medical. This difference is probably not of significance to the average Naval physician, but it can make a difference at times because these two commands (and people) will look at things from a different perspective.

For example, lets say you are one of two subspecialists at NH Camp Lejeune and you have a fairly light clinical load. You decide you want to leave early to get to your next command, Naval Medical Center Portsmouth (NMCP), because they are actually down one provider in your specialty due to the illness of another member of your community. Your Specialty Leader will probably endorse this early move because it makes sense. You are underemployed at Lejeune and there is a need at NMCP. Your Detailer, however, will look at it differently. First, you haven't served your full tour, so moving you early will require a waiver that may be denied by PERS. This largely has to do with money and PCS rules and has nothing to do with your specialty or the needs of the Navy. I'm not saying that Detailers don't care about the needs of the Navy because they do, but they are constrained by the rules of PERS while a Specialty Leader is not.

DIFFERENCE #2 – WHAT THEY DO

A Specialty Leader serves as a liaison between you, BUMED, and your specialty as a whole. He or she also coordinates deployments, although the control they have over this was lessened by the return to platform-based deployments (deployments determined by what billet you are in or what unit/platform you are assigned to rather than whose turn it is to deploy). They also serve as a consultant both to you and your Detailer when it comes to career management and PCS moves.

A Detailer is your advocate to help you advance in your career, prepare for promotion boards by improving your officer service record, and negotiate orders for your next PCS. They will often speak with both you and your Specialty Leader while trying to balance your needs with the needs of the Navy. They also are the final approval authority for extension requests and actually write your PCS orders.

DIFFERENCE #3 – WHAT THEY DON'T DO

Specialty Leaders do not write orders. Many physicians think that the Specialty Leader is the one who decides what orders they get and where they PCS, but the reality is that Specialty Leaders can't write orders. Only Detailers can, therefore it is the Detailer who makes the final decision in nearly all cases.

If there is a good Specialty Leader-Detailer relationship, most of the time both are in agreement and there is no controversy, but about 5% of the time there is at least some level of disagreement that has to be worked out.

Detailers can write your orders to a command, but they do not influence who gets command-level leadership positions. For example, you may want to go to Jacksonville to be the Department Head of your specialty's department. A Detailer can write you orders to Jacksonville, but which physician the command picks to be Department Head is up to them, not the Detailer (or the Specialty Leader).

Specialty Leaders will often talk to commands, but Detailers usually do not. The Detailer is SUPPOSED to talk to three people – you, the Specialty Leaders, and the Placement Officers. The Placement Officers are officers at PERS who represent the commands. You can think of them as the detailers for commands. They make sure that commands aren't taking gapped billets, that the providers sent to the command meet the requirements of the billets they are entering, and weigh in on other issues like extension requests.

I say that a Detailer is SUPPOSED to talk to three people and USUALLY does not talk to commands, but the reality is that commands frequently call the Detailer instead of talking to their Placement Officers. This often happens because the Director at a command knows the Detailer but doesn't know the Placement Officer. In addition, the Detailer is usually a physician (three of the four Medical Corps Detailers are physicians, the 4th is a MSC officer) and the Placement Officer is always a MSC officer. In my opinion, physicians often prefer talking to other physicians.

Finally, Specialty Leaders do not alter your officer service record. In fact, unless you send it to them, they can't even see it or your FITREPs. Detailers, on the other hand, can see just about everything and can update/change some things, mostly additional qualification designators (AQDs).

WHY SHOULD YOU CARE ABOUT ANY OF THIS?

Because you must actively manage your career to get what you want. This means you should talk with both your Specialty Leader and Detailer 9-18 months ahead of your projected rotation date (PRD). You should discuss your short and long-term goals, whether you want to PCS or extend, whether you are planning a Naval career or want to resign or retire, your family situation, and your medical situation, if applicable.

Most importantly, though, is to be honest with both your Detailer and Specialty Leader. Most Specialty Leaders get along well with the Detailer, so if there is any disagreement between the three of you make sure that you keep things professional and respectful at all times. It's a small Navy and, to be honest, it will be readily apparent if you are playing one off against the other.

Navy Ophthalmologists Play Key Role in Navy's Global Healthcare Engagement Mission

by CAPT Frank Bishop, Ophthalmology Specialty Leader

In 2016, Navy Ophthalmology will once again play an important role in the implementation of the Navy's Global Healthcare Engagement mission. As has been the case since the first Pacific Partnership mission in 2006, Navy Ophthalmologists will perform cataract and other surgeries to hundreds of patients throughout the Asia-Pacific region. This year, ophthalmologists from Naval Medical Center San Diego are also playing integral roles in the leadership and planning for Pacific Partnership 2016. Commander John Cason, MD is the mission's Director for Surgical Services (DSS) and is already actively engaged in planning and resourcing the critical surgical mission. Commander Andrew Doan, MD is already traveling across the region in his role as Assistant Director for Medical Operations and Planning(ADMOP), helping to ensure the success of the mission by clearly defining host nation goals and engagement objectives. Additionally, Captain Sayjal Patel will fulfill the role of Mission Ophthalmologist, and is already busy inventorying supplies and preparing lectures and other engagement tools required to ensure success.

The work done by this team is more than sight saving, it is often life changing. Cataracts are the number one cause of blindness in the world; and for many of those effected with this condition, their disability not only affects their lives, but also those of the families who must now support them. The team looks forward to changing lives and sharing skills with partnering physicians who can carry on the good works for many years.

Navy Ophthalmology Leads Refractive Surgery Safety and Standardization Efforts

Over one hundred ophthalmologists, optometrists, clinic managers and surgical techs gathered in sunny San Diego, CA, for the Military Refractive Surgery Safety and Standards Symposium (MRSSS) June 10-12, 2015. Refractive surgeons and their teams shared lessons learned, surgical techniques, and patient vision outcomes from all three military services around the globe. This was the first DoD-wide training symposium to facilitate refractive surgery collaboration, patient safety improvement and policy alignment.

Many differences exist amongst the military services for the delivery of refractive surgery care. For example, Naval Aviators must be treated by Navy refractive surgeons. Implantable collamer lenses (ICLs) are not authorized in the Air Force. However, the MRSSS training symposium provided an opportunity for all three services to discuss their policy differences and propose the possibility of collaborating for future policy decisions.

Refractive surgeons delivered salient lectures regarding safe surgical techniques for LASIK, PRK, and ICL surgery. Decision rationales for choosing amongst these procedures highlighted each of their advantages and limitations to enhance safety and vision outcomes. Research findings amongst all three services elucidated the possible future directions for vision enhancement procedures. Investigators reported great promise for new techniques that might benefit our nation's warfighters. Most importantly, this symposium was not just for surgeons. All aspects of the refractive surgery continuum collaborated together to enhance the patient experience from scheduling to postoperative care to their return-to-duty. The symposium was very highly received by all participants who universally desired to make the training an annual event. The next MRSSS is currently scheduled for June 8-10, 2016, in San Diego, CA.

OFFICE OF THE CHIEF OF THE NAVY MEDICAL CORPS

Deputy Chief of the Medical Corps
CAPT Mae Pouget, MC, USN
Direct: (703) 681-8917 DSN 761-8917
mae.m.pouget.mil@mail.mil

Medical Corps Career Planner
CAPT Jamie Oberman, MC, USN
Direct: (703) 681-8937 DSN 761-8937
James.P.Oberman.mil@mail.mil
jamieandmeg@msn.com

Plans and Policy Officer
CAPT Greg Thier, MC, USN
Direct: (703) 681-9128 DSN 761-9128
gregory.t.thier.mil@mail.mil

Reserve Affairs Officer
CAPT Alison Eagleton, NC, USN
Direct: (703) 681-8938 DSN 761-8938
alison.p.eagleton.mil@mail.mil

HPSP/Recruiting Fellow
LCDR Jami Peterson, MC, USN
Direct: (703) 681-8928 DSN 761-8928
jami.j.peterson.mil@mail.mil

NAVY PERSONNEL COMMAND MEDICAL CORPS DETAILERS

Head, Medical Corps Assignments
Surgical/Executive Medicine Detailer
CAPT Anthony Battaglia, MC, USN
Direct: (901) 874-4094 DSN 882-4094
anthony.g.battaglia@navy.mil

Non-Surgical Medical Specialties
CDR Joel Richard Childers
COMM: (901) 874-4046 or DSN 882-4046
richard.childers@navy.mil

Family and Operational Medicine
CDR Samya Cruz, MC, USN
Direct: (901) 874-4037 DSN 882-4037
samya.cruz@navy.mil

GMO and GME Detailer
LCDR Deepak Devasthali, MC, USN
Direct: (901) 974-4045 DSN 882-4045
deepak.d.devasthali@navy.mil

Office of the Chief of the Navy Medical Corps
U.S. Navy Bureau of Medicine and Surgery
7700 Arlington Blvd., Suite 5135
Falls Church, VA 22042-5135

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- **Order quantity (1-10)**
- **Good mailing address (home is best)**
  - FPO AE/AP must include zip+4 & local phone for US Customs form

Once email is received, CAPT Thier will confirm order, and advise of exact amount due, as well as specific check payment information (sorry, no credit card/PayPal option).

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Contact CAPT Jamie Oberman at: James.p.oberman.mil@mail.mil if interested

All donations/proceeds to go towards Medical Corps Birthday Ball