

NAVY MEDICAL CORPS NEWS



From your Medical Corps Chief, CAPT Paul Pearigen:

I invite you to reflect for a few minutes on your experience of service. Specifically, your experience of service as a physician and Naval officer. Experience is a compilation of moments—events, places, people, sensations. An aggregate of assignments, locations, patients, teammates, peers, family. Brief episodes and drawn-out encounters alike.

For some, your Navy path started as the child or other close relative of a service member, making the life of the military uniform a natural and deeply resonant part of your family history. For others, it came much later in your personal path, requiring that your experience in a civilian educational and career upbringing undergo a re-orientation into the heritage and ethos of the Navy. For many, your prior service as an enlisted Sailor, Marine, Soldier or Airman forms a central part of who you are and how you go about your work today as a Navy physician. Those of you who spent part of your career in the Nurse Corps or Medical Service Corps—and those who came to medical school from the line Navy or Marine Corps—bring a particular richness and perspective to the combined role of physician and officer.

And whether your time as a Medical Corps officer has been brief thus far or has involved years with training, advancements, deployments, moves, and opportunities gained and lost, your physician experience of service has been broadened and enlivened, and at times burdened and challenged, by practicing your profession in uniform. Throughout, your patients have been part of the broader family of our Navy and Marine Corps. A family of which we are also members.

No two of us would describe an identical experience of service; but our shared experience, and the overlapping moments, help define—and distinguish—us as a Navy Medical Corps.

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SPRING 2016

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From the Corps Chief (cont.)

When I reflect on my own experience of service, I think of the professionalism and mission-focus of those with whom I've had the opportunity to work and from whom I've undoubtedly learned. I think of the teaching and development that are foundational to the Navy medical department. I think of what I've been through as a leader—and as a follower. I think of the humility displayed by those particular colleagues who are among the most courageous and selfless servants I've encountered (and are generally among the best docs as well). I also think of the experiences I would have missed had I not embraced (or at least willingly accepted) orders, tasks, or opportunities the Navy handed to me.

Do we all always get every perfect set of orders, or the most comfortable and ideal position? No. Do we get to stay in one place or one position for years on end, even if we are really good at it? Again, not typically. Do we sometimes find the next rotation inconvenient for our personal plans, family situation, or short-term professional goals? Yes. But ultimately the Navy, Navy Medicine, and we

as officers and physicians leaders are better for it. Indeed the heritage of Naval and Joint service includes moving, changing, adjusting, adapting, developing, and taking on new and advanced skills and responsibilities—and in so doing becoming better selves, broadening our experience of service, and allowing our peers to step in and build upon what we accomplished in the billets we turn over to them.

As long as you remain in uniform, I hope you see your experience of service as I do mine: irreplaceable... but incomplete.

As I said at the beginning, I invite you all to reflect on your experience of service, regardless of the stage of your career. Seek, and be open to, opportunities, invitations, and even orders to expand, adjust, redirect, or relocate the way in which you practice your profession of healing, your calling to wear the uniform, and your drive to make a difference. Don't let a focus on comfort undermine your experience of service, shortchanging yourself, your patients, the shipmates and families you serve, and our nation.



Call for Summer issue articles

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

Career Planner Words

It has truly been an honor and privilege to serve as the USN MC Career planner since July 2014.

I hope that I have improved transparency across the community, as well as leadership development and mentorship initiatives. Talent management is imperative for retention, resiliency and medical corps job satisfaction. This process starts from our office, with specialty leaders. Our creation of the annual business meeting has recognized the importance of improving mentorship at all levels, starting with Specialty leader development. These leaders can, in turn, mentor their colleagues and constituents throughout the globe: but we must also hold these leaders accountable and institute mid-term evaluations for refinement.

Specialty leaders and the corps chief's office must advocate for and represent all MC officers well.

Leadership course opportunities, to include Navy Senior Leadership Symposia (NSLS), CAPSTONE, Interagency Federal Healthcare Executives, Healthcare management, Medical Senior Leadership Program (MSLP), AMDOC, among others will continue to be promoted and endorsed. We will continue to advocate for the MC at all levels throughout our organization.

It is an honor to introduce CAPT Robert Alonso, as my replacement. We have begun informal turnover, with intention for formal succession NLT 1 August 2016.

Best regards, Jamie Oberman



Captain Robert A. Alonso
Medical Corps, USN

CAPT Alonso holds a Bachelor of Arts degree in Biology from the University of Louisville, Louisville, KY, a Master of Arts in National Security and Strategic Studies from the Naval War College, Newport, RI, and a Doctor of Medicine degree from the University of Louisville, School of Medicine.

CAPT Alonso's military career began in 1985 as an Ensign in the U.S. Navy Medical Corps through the Health Professions Scholarship Program while a medical student at the University of Louisville School of Medicine. Upon graduating in 1988 with an M.D., he received a commission as a Lieutenant in the U.S. Navy Medical Corps. He completed his Family Practice Internship at Naval Hospital Charleston, South Carolina, then reported as Battalion Surgeon, 5th Bn/11th Marine Artillery Regiment stationed at 29 Palms Marine Corps Air Ground Combat Center, CA. Following his general medical officer tour, he reported to Naval Medical Center Portsmouth, Virginia for his Psychiatry Residency, graduating in June 1993. From July, 1993 to 1996, he served as Inpatient Director then Department Head of the Psychiatry at


Naval Hospital Okinawa, Japan. In July 1996, he reported as Division Psychiatrist/Assistant Division Surgeon for the 1st Marine Division, Camp Pendleton, CA. He assumed the duties as Group Surgeon for 1st Force Service Support Group, I MEF in August 1999. In 2000, he deployed with 1st Marine Expeditionary Brigade to Kenya and Tanzania as the Combined-Joint Task Force Surgeon for Exercises Natural Fires/Native Fury.

CAPT Alonso was selected to attend the Naval War College and graduated with an M.A. in November 2002 and reported for his joint tour to Joint Task Force-Civil Support (JTF-CS) as Command Surgeon. During this tour he participated in the development of the mission scope, concept of operations, and manning requirements for the NORTHCOM Surgeon's Directorate.

Following his tour at JTF-CS, he was selected as Department Head for Psychiatry at Naval Medical Center Portsmouth. In October 2006, he reported to FIRST Naval Construction Division as Force Surgeon, charged with the medical readiness and healthcare of the 18,600 man force. He reported as Executive Officer of Expeditionary Medical Facility Kuwait in December 2009 for a one year deployment, providing Level III health services to the Kuwait and Northern Persian Gulf areas. Upon redeployment in January 2011, he served as Combat and Operational Stress Control Consultant for Individual Augmentee mental health issues to the Director, N1, Fleet Forces Command. In June 2011, he reported to Headquarters Marine Corps as Deputy, Medical Officer of the Marine Corps. During his tenure, the Marine Centered Medical Home was implemented for all garrison care. He reported as Executive Officer, Naval Health Clinic, Quantico, Virginia in January 2014. The Corps Chief's Office is eager to welcome him aboard this summer.

Conference Travel Update

SUMMARY OF MAJOR CHANGES:

FORMAT CHANGES (see templates ) Starting in April 2016, packets will be sent back to SL/QM upon accession if the formatting of the ADS and attendance rosters does not follow the guidance below

1. First and foremost: CME info is requested on EVERYONE and should be listed FIRST in the "reason for attendance" box on the ADS. The CME info should be stated in a standardized way (example provided to the right.) If the attendee is a resident OR if an attendee does not need CMEs, state that in the CME section (see example).
2. List all reasons for attendance. Yes we are back to that. The one good thing is that repetitive or "cut and paste" reasons are not as discouraged as much. (Standard examples are provided below.)
3. Reason for attendance headings (ie CME, PRESENTING, COMMITTEE MEMBER, SKILLS ENHANCEMENT, GME LEADER) need to be in ALL CAPS and BOLD. The attendance reasons also need to be separated on different lines, (see examples).
4. The ADS and Attendance roster names need to be in the SAME ORDER. So the ADS and attendance roster lists need to read the same from top to bottom.

TEMPLATE #1: STAFF WHO IS PRESENTING:

CME: CA state license requires 30 category 1 CMEs every 2 years. Attendee currently has 3 CMEs for gathering cycle ending in 2017.

PRESENTING: "Diagnostic Approach to Atypical Chest Pain in the Young Female." Presentation is on 5/2/2015.

SKILLS ENHANCEMENT: Attendee has been OCONUS for 2 years with limited ability to perform certain critical procedures to her specialty. This even offers a hands-on procedural workshop which will provide valuable skills enhancement.

****CME is listed first and included on every attendee. Since this person needs CMEs AND is presenting, no specific "attendance plan" needed. Fortunately this can be inferred in this case.**

TEMPLATE #2: THE PRESENTING RESIDENT:

CME: Attendee is a resident and does not need CME.

PRESENTING: "Antibiotic Prescribing Practices in Civilian versus Military Urgent Care Centers." Presentation is on 5/2/2016.

SKILLS ENHANCEMENT: Although attendee is not attending specifically for CME, they are expected to attend all academic sessions, work-shops and panel discussions when they are not presenting.* This provides valuable skills enhancement and professional development. Additionally, attendance meets ACGME requirements for participation in scholarly activities on the national level, which is critical for maintaining residency accreditation.

****This is our first example of an "attendance plan" where we are accounting for the rest of the time at the conference.**

TEMPLATE #3: CME ONLY ATTENDEE:

CME: CA state license requires 30 category 1 CMEs every 2 years. Attendee currently has 3 CMEs for gathering cycle ending in 2017. (listed first and included on every attendee).

All CMEs earned will be applied to licensure requirements.

****NOTHING FURTHER NEEDED (at least for now).**

TEMPLATE #4: THE STAFF PRESENTER WHO DOES NOT NEED CME:

CME: Attendee does not need CME.

PRESENTING: "The Relationship between Work Stress and Early Cardiovascular Disease." Presentation is on 5/3/2015.

SKILLS ENHANCEMENT: Although the attendee is not specifically attending for CME, attendee is expected to attend all academic sessions, workshops and panel discussions when he is not presenting. This provides valuable skills enhancement and professional development in one multipurpose trip.

****The "skills enhancement" contains an "attendance plan" for the attendee who doesn't need CMEs, is presenting and wants to attend the rest of the conference. ALTERNATIVELY, the presenter who doesn't need CMEs can leave the conference after their presentation (be SURE that is reflected on their travel dates). Either way, packets have been getting kicked back to account for the time/activities.**

TEMPLATE #5: THE VITAL COMMITTEE MEMBER WHO DOES NOT NEED CME:

CME: Attendee does not need CME.

COMMITTEE MEMBER: Attendee is the Chair of the National Ethics in Medicine Committee that meets on 5/4/2016.

SKILLS ENHANCEMENT: Although attendee is not specifically attending for CMEs, attendee is expected to attend all academic sessions, workshops and panel discussions, when she is not meeting with the committee. This provides valuable skills enhancement and professional development in one multipurpose trip.

****The "skills enhancement" again contains an "attendance plan" for the attendee who doesn't need CMEs, is a committee member and wants to attend the rest of the conference. ALTERNATIVELY, the committee mbr who doesn't need CMEs can leave the conference right after their committee meeting (be SURE that is reflected on their travel dates). Either way, packets have been getting kicked back to account for the time**

Plans & Policy Update

Recently, the Surgeon General, VADM Forrest Faison, held a Town Hall meeting at BUMED to discuss some issues that are meaningful to him. Among many topics he discussed, one that showed promise to swing Navy Medicine in a new direction with regards to our patients' health was the concept of Value Based Care. The ultimate goal in Value Based Care is to improve the overall health outcomes that matter to patients relative to what it costs to achieve those outcomes. In other words, ensuring that we are focused on what is really important to our patients without increasing our overall dollars we spend. There are some large organizations that have been attempting Value Based Care across the globe with apparently good success in achieving those goals. The SG promises that if we can achieve this new model of care, we can ditch the need for counting our RVUs as though our patients were merely widgets on a factory line and get down to doing what we all became Navy physicians for, to provide healthcare to the sons and daughters of the US.

Turning a concept into a working model of healthcare is no easy road. For those of you involved in the Patient Centered Medical Home and its inaugural years in Navy Medicine, you know all too well that change never comes easy. The SG has decided to try out a proof of concept model of Value Based Care and has established a team at BUMED to determine the ground rules and set up Value Based Care at a single pilot site. While the pilot site implementation is still several months away, it may not be a bad idea to become at least familiar with the concept. A good article to read about what Value Based Care consists of is at:

<https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>

Another topic of particular interest to the SG was the realization that the majority of our Navy (and entire DoD writ large) is composed of Millennials. Millennials approach their health care in vastly different ways and likely aren't as receptive to using older methods of health care delivery. For example, Millennials would much rather use an app to schedule a medical appointment rather than dial up (just by using that phrase, I've identified myself as a non-Millennial) a phone. To help with meeting our patients own goals and expectations, there is a new group at BUMED dedicated to working with technology and how best to leverage it for them. Since at least a third of you reading this are Millennials and probably keen on bringing the Navy up to speed with the rest of the nation, there is a milSuite site that is dedicated to doing just that. Go to Digital Health: <https://www.milsuite.mil/book/groups/digital-health> and check out their resources and provide your input on how to make Navy Medicine Millennial-friendly.

Lastly, since this is going to be my last entry as Plans & Policy, I wanted to share some of my perspectives on working at BUMED. To be up front about it, I had actually avoided coming to BUMED for several years. My understanding for most of that time was that BUMED was a place of sorrow and unhappiness. I thought that everyone that came here was simply trying to get ahead and didn't care about those poor people in the MTFs and had no clue as to what was really going on. Another notion that I had was that in order to get ahead of the person next to you was to get here

earlier in the morning and leave later than them. That would be the only way to show your dedication. With all of those ideas in my head as to what life was like here, I wanted nothing to do with it.

I am happy to report that I was wrong. The people here are truly dedicated to ensuring that people at the deckplates get what they need and concerns are addressed. I haven't seen anyone here becoming a skeleton at their desk because they felt they couldn't leave. It seems that most everyone here is fairly happy with the work they are doing and appears to be satisfied. Now, I'm not wearing blinders. I know that things are not perfect here. Things can seem to take a lifetime to get accomplished. That piece of equipment you need to take care of your subset of patients is taking forever to get there. Most of the speed and efficiency issues that I'm sure you have at least heard of are really a symptom of BUMED being a large and complex organization. This is no-fault of any one particular person and in fact several people here have been working for the last few years trying to improve the speed and efficiency.

I want to encourage you to consider spending a tour here at BUMED if you truly want to make an enterprise-wide difference. There are few other places that you can go in Navy medicine that can allow a person to have that great of an impact on that many people. Your reward at the end may be more than just the next job or a promotion. You may just leave satisfied that you've been part of something bigger than yourself.

Medical Corps Reserve

EMF CAMP PENDLETON LAUNCHES ITS FIRST EXERCISE AT NEMTI

Sixty-seven Enlisted and Officer Members of Navy Reserve Expeditionary Medical Facility, Camp Pendleton (EMF-CP) attended training at the Navy Expeditionary Medicine Training Institute (NEMTI) onboard Marine Corps Base Camp Pendleton in June 2015. EMFs are designed to be mobile, agile, medical units which can be comprised into a sophisticated level of care that is "tailorable" and "scalable" in order to support future Navy expeditionary requirements. The platform is being manned to be able to deploy 10-bed, 50-bed or 150-bed capabilities dependent upon the concept of operations and expected casualties.



Expeditionary Medicine is a distinct specialty within medical related fields and Reserve members of the EMF will be expected to provide care under arduous and exceptional circumstances where the environment may be austere and hostile. Once fully developed, the EMFs will have the capability to render care in the air, on the sea and on the ground with specialized training.

The first step in EMF training is to learn first-hand the equipment necessary to provide advanced medical care in an expeditionary environment. NEMTI, positioned in the desert-like conditions of California provides the

perfect setting. As the first operational training exercise for EMF-CP, the objectives were to configure, assemble and disassemble Tent Extendable Modular Personnel (TEMPER) and International Standard Organization (ISO) components which comprise most of the EMF modules within the facility. Construction of the EMF hospital requires the assistance of Seabee units which will deploy with the EMF in a real world scenario.

EMF-CP was joined by Seabee Construction Maintenance Unit 202, Detachment Jacksonville and Seabee Construction Battalion Reserve units 202 and 303. While the Seabees direct the construction efforts, all personnel are required to pitch in. NEMTI staff coordinated didactic and deployment skills to successfully construct a 50 bed hospital. Once the EMF hospital was complete, a Collective Protection (COLPRO)

system was introduced and a Chemically Hardened facility (CH-EMF) was erected and later disassembled.

COLPRO allows an EMF to continue to operate in an environment which may be contaminated by biological, chemical or nuclear agents. Didactic training provided a solid foundational background including the history of the EMF and its evolution from the large and far less agile 500 bed Navy Fleet Hospital platform.

*By Thomas A. Damato, CAPT, MC, USN
Senior Medical Executive, NR EMF-CP HQ*



Recent military conflicts highlighted the need to develop a smaller, more light-weight deployable capability which can arrive and set up quickly as close to the conflict or site of disaster as possible. The new EMFs are being designed to answer that call. EMF platform development will likely include a modular design which can be configured on shore or at sea.

EMF-CP is the 4th and final Reserve command to be commissioned in the EMF program. EMF-CP sailors can be proud of their Command's success at NEMTI. Bravo-Zulu to all for a job well done!



Navy Medicine Commanding Officer/Executive Officer Screening and Slating Process.

The process for screening and selecting officers to Navy Medicine Commanding Officer (CO) and Executive Officer (XO) positions begins each fiscal year (FY) with the issuance of an announcement, historically sent as a BUMED Notice (BUMEDNOTE 1412), that announces the administrative screening board and describes qualifications, criteria, processes and application procedures. Further information regarding administrative screening is provided in MILPERSMAN 1301-811.

Officers interested in CO/XO opportunities submit application packages directly to Navy Personnel Command, PERS-4415. Applications include a letter of recommendation from the applicant's CO and an endorsement from their Flag Officer ISIC.

Following receipt of applications, PERS-4415 notifies the Deputy Surgeon General (DSG) of officers that require an oral screening board. Officers desiring to screen must complete an oral board to assess the officer's understanding of and readiness for the responsibilities of command.

The DSG directs Navy Medicine Flag Officer(s) to select oral board membership and convene the oral board(s). Per BUMEDINST 1412.1A, officers must successfully pass the oral board to be screened on the Medical Department CO/XO administrative screening board.

The CO/XO administrative screening board is held in September of each FY. The board sponsor is PERS-4415 and board membership includes Navy Medicine Flag Officers. Following the board process, board results are released from Navy Personnel Command to the Surgeon General (SG). Officers that successfully screen are considered eligible to fill CO and XO positions in Navy Medicine.

Upon release of the administrative screening board results, the Deputy Corps Chiefs contact screened officers from each of their Corps to discuss their preferences for CO or XO assignments, though it is expected that that applicants are "world-wide assignable". Screened officers understand that if slated, they will be assigned based on the "Needs of the Navy".

The Corps Chief Deputies prepare a slate that includes the desired skill sets/personality traits of COs and XOs for each position and match officers to these positions based on their experience and qualifications; the Deputy Corps Chiefs work with Senior Detailers and the Corps Chiefs to slate officers to CO and XO billets.

Once a proposed slate has been reviewed and approved by the Council of Corps Chiefs, it is forwarded to the SG, via the DSG, for review and approval. The approved slate is then released to Navy Medicine upon approval by the SG.



Congratulations, Captains (select)!



The results of the FY-17 O-6 Staff Selection Board that convened on 2 February were released on 27 April. Please join the Chief of the Medical Corps in congratulating these Medical Officers who have been selected for promotion to the rank of Captain!

Akins Roger Scott
Alsina Manuel F
Altamar Hernan Orlando
Ancona Michael R
Antle Susan Farrar
Berry Kyle R
Bunten Bradley L
Bustamante Alexander I
Callan James E
Carr Russell B
Dalitsch Walter W
Demers Gerard
Ellingson Christopher
Espiritu Jennifer M
Feldman Brian L
Franzos Marc A
Gallus Katerina Maria
Gilhooly Jonathan E

Gonzalez Hermann Franc
Hagerman Rodney S
Hanley Keith A
Hanling Steven R
Hussey Sean M
Johnson David P
Juliano Michael L
Klugh Arnett
Lavery Eric A
Lee Mike Hyun
Lenart Mark J
Lujan Eugenio
Matwiyoff Gregory N
Mclean Matthew David
Moroney John W
Nanos George P III
Norris Craig Dewayne
Omeara Kevin Michael
Orsello Christopher A
Penta Joseph F
Powell Blaine Michael
Quast Timothy M
Rader Scott B
Ramirez Alfredo R
Randall Craig J
Ricca Robert L
Rice George M
Robinson Michael A
Rue John Paul Harris
Sanchez Marlene L
Sayles Timothy E
Schiemel Andrew W
Shiau Danny T
Shippey Stuart H III
Shusko Michael P
Spalding Bryan M
Spooner Michael T
Stedjelarsen Eric T
Steigleman Walter A
Temple Richard W
Thomas Karin E
Tucker Anthony
Wells Brian P
Whittaker David Robert
Wilson Charles E
Wittenberger Michael D

Historical Characteristics of Selectees FY-16 O-6 MC

Precept: 50% of IZ Officers or
51 to select

155 Above Zone

101 In Zone

164 Below Zone Eligibles

Above Zone Selects 11/155,
or 7.1% of all AZ; 21.5% of all
selects.

In Zone Selects 39/101, or
38.6% *in-zone selection rate*;
76% of all selects.

One Below Zone Select

More from FY16 Board:

98.1% with no PFA failures
last four cycles

3 Fitreps before Board: 39.2%
had 2 EPs; 27.5% had 3 EPs.

98.5% Board Certified



Pacific Partnership Scholarly Activity Fair Held at NMCS D

by CDR Dylan E. Wessman, MC, USN

The inaugural “Pacific Partnership (PP) Resident and Faculty Scholarly Activity Fair” was held at Naval Medical Center San Diego (NMCS D), on Friday, 5 February 2016. This unique event was planned as a forum to showcase the challenging cases, research, and quality improvement projects performed by Navy Medicine West residents, fellows, and faculty members during PP 2015 – and as a means of promoting continued scholarship during PP 2016.

More than 115 personnel attended the fair, including Capt. José Acosta, Commanding Officer, NMCS D, Capt. Melanie Merrick, Commanding Officer, Medical Treatment Facility USNS MERCY (T-AH 19), Executive Steering Committee members, Medical Executive Committee members, and residents, fellows, and faculty from both NMCS D and Naval Hospital Camp Pendleton (NHCP).

During PP 2015, the MERCY brought medical and surgical services to the host nations of Fiji, Papua New Guinea, Philippines, and Vietnam. Thirty seven residents, two fellows, and more than 20 faculty members from sixteen graduate medical education (GME) programs were selected to participate in PP 2015. They performed clinical and educational activities, including surgical

engagements aboard MERCY and ashore, community health exchanges at local clinics, community outreach teams to remote villages, and subject matter expert exchanges in local hospitals.

The Navy Medicine West trainees and faculty collaborated with physicians and nurses from the four host nations, five partner nations (Australia, Japan, Malaysia, Korea, and New Zealand), and non-governmental organizations such as Project Hope, Operation Smile, and Latter Day Saints Charities. Thus, PP 2015 provided a unique opportunity for trainees and faculty alike to receive valuable clinical experience and education in health care disparities on a global scale and to participate in initiatives to address those disparities.

During and after their PP 2015 rotation, the residents and fellows were required to work with their supervising faculty members on a

case report or case series, research project, quality improvement project, or critical reflection. Thirty one abstracts – coauthored by 34 residents, 2 fellows, and 25 faculty members from 17 GME programs – were submitted for the first ever PP Scholarly Activity Fair. Eight abstracts were selected for podium presentation, the remainder for poster presentations. Nine of those presentations were multidisciplinary, involving trainees and faculty from two or more GME programs. Attendees of the fair included 55 trainees and 46 faculty.

The NMCS D leadership plans to repeat the Scholarly Activity Fair after each PP mission, extending the beneficial impact from host nation patients, nurses, and physicians to our stateside GME programs, parent commands, and Navy Medicine at large.



LT Brandon Hadfield (Pediatrics resident) during PP 2015 Scholarly Activity Fair poster presentation.



MC Officers at Kandahar Role 3 (Oscar Rotation) celebrating the MC Birthday.

News You Can Use

Specialty Leaders

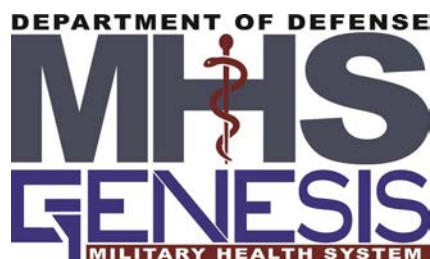
Please join the Chief of the Medical Corps
in welcoming several new specialty leaders:

Heme/Onc - CDR Heather Tracy
Neonatology - CDR Karina Volodka
Vascular Surgery - CDR Nathan Fernandez
Infectious Disease - CAPT Timothy Burgess

Reservists

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

New EHR has a name now:



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

Billet Assignments

Primary consideration for selection
for orders involves each of the
following:

The needs of the Navy, career needs
of the individual, and desires of the
individual.

Needs of the Navy: This is the
primary consideration in each officer
assignment and is taken into account
prior to all other factors. These needs
are met by filling a valid billet
requirement with the most qualified
officer available.

Career Needs of the Individual:
Detailers are mindful of specialty
requirements, opportunities and each
officer's career experience all are taken
into consideration when orders are
generated. These different decision
points include weighing different types
to duty stations (developing a diverse
portfolio), as well as choosing the right
officer based skill set, rank, future
plans (talent management.)

Desires of the Individual: The desires
of the individual are important, and
assignment can affect the morale of the
officer and, in many instances, the
military family. Detailers try to
support officers' requests when making
assignments, but the needs of the Navy
and desires of the officer don't always
align.



2016 Medical Corps Birthday Ball Held in Bethesda, Maryland

This year's Medical Corps Birthday Ball was held in honor of the 145th birthday of the Medical Corps. The Ball consisted of dinner, dancing, a silent auction, and wonderful speeches by notable giants in the Medical Corps community. A highlight of the evening was a presentation by BG(ret) William Weise, a retired Marine Corps Officer and recipient of the Navy Cross for heroism during the Vietnam conflict, where he discussed his love and admiration for Navy Medicine and our efforts during the war.

Many thanks to several people who made the Medical Corps Ball a huge success this year!



BG(ret) Weise speaks at the MC Birthday Ball

Experiences with the Undersea and Hyperbaric Medicine Fellowship

by CDR Brad Hickey, MC, UMO

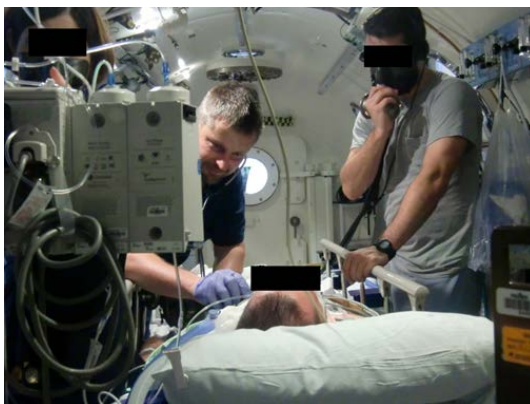
I have had the pleasure of participating in an Undersea and Hyperbaric Medicine Fellowship at LSU Health Sciences Center New Orleans over the previous 9 months. The education has been fantastic and New Orleans is a wonderful city to live near. My experiences have included beginning fellowship in the LSU Interim Public Hospital System (Post Hurricane Katrina Facilities) and then transitioning into the newly opened University Medical Center New Orleans. I also see patients at West Jefferson Medical Center, a community hospital near New Orleans. At these two facilities I have gained experience with two different types of monoplace hyperbaric chambers and a multiplace hyperbaric chamber that is critical care capable.

As part of my fellowship I have supervised hundreds of routine hyperbaric treatments and have been directly involved with two critical care hyperbaric treatments, both of which included unconscious intubated patients with severe decompression illness. These experiences are invaluable to me and will allow me to bring this skillset and knowledge back into the Navy Undersea Medicine Community.

My fellowship education has consisted of direct patient care, research/academic projects, weekly academic grand rounds, monthly dive medicine conferences with other fellowship programs, and the program supported my attendance at the

NOAA Physicians Training in Diving Medicine Course. This was a great opportunity to learn more about commercial and scientific diving along with some unique aspects of hyperbaric medicine such as medical support for caisson and tunneling work.

I would encourage any current or former UMOs to contact me if interested in learning more about the fellowship at hickeybw@hotmail.com. A physician may apply to the hyperbaric medicine fellowship from any medical specialty. Notable hyperbaric physicians have come from diverse specialties such as



CDR Hickey providing critical care hyperbaric medicine to an unconscious, intubated patient at a chamber depth of 100 feet of seawater.

cardiology, orthopedic surgery, radiation oncology, occupational medicine, anesthesiology, and emergency medicine. For active duty Navy physicians, only qualified UMOs can apply for the fellowship as you will serve in a UMO billet following graduation. If interested in applying for hyperbaric fellowship training, please contact the UMO Specialty Leader to discuss this great opportunity.



CDR Hickey taking a break from working on a flange and gasket at the NOAA Dive Training Facility in Seattle, Washington.

Finally, any physicians that are separating or retiring from the Navy and would like a career change, please consider hyperbaric medicine. After completing a one year fellowship, you will be a wound care and hyperbaric medicine specialist that is in high demand.



CDR Hickey following a surface supplied dive at the NOAA Dive Training facility in Seattle, Washington.

OB/GYN News

NMCS D Launches Contraception Walk in Clinic

by LCDR Kerrie Adams, MD, MCR, Department of Obstetrics and Gynecology, Naval Medical Center San Diego

SAN DIEGO, CA-The Department of Obstetrics and Gynecology is proud to announce the successful opening of a same day service contraception clinic. Operation PINC: Process Improvement for Non-delayed Contraception offers a full range of contraception options for women and adolescents without the need for an appointment.

The Department of Defense has recently fallen under intense scrutiny in the popular press for the nearly double rate of unintended pregnancy rate of active duty women compared with civilian women. Active duty women have access to excellent health care including free birth control, however, there can be many barriers to obtaining contraception including appointment wait times and time conflict with duty hours and deployments. Unintended pregnancy costs the Department of Defense not only in money for medical care but also in lost man hours, as pregnant active duty women are non-operational for approximately 20 months per pregnancy. Operation PINC is a process improvement project created to remove barriers to contraception, increase access to care for all women for family planning services, and ultimately decrease the unintended pregnancy rate for San Diego sailors. Operation PINC is staffed by NMCS D staff and

resident physicians and is open Monday through Thursday 8:30-3:30 and Fridays 12:30-3:30. From the time of initiation of the project on 2/1/2016, the clinic has seen over 500 patients and averages 12 patients a day. The project has developed several clinical tools including an easy to use screening form for quickly assessing a woman's risk for using hormonal contraception and a portable cart stocked with readily accessible procedural instruments. The mean age of women presenting for care in the PINC clinic is 25 years and 70% of attendees are active duty, meeting the targeted demographic of the project. Operation PINC has doubled the reported initiation rate of long acting reversible contraception (LARCs) for the military from 21% to 44%. LARCs are recommended by the Center for Disease Control and several medical societies as the most effective method for preventing unintended pregnancy. Operation PINC is a cost effective initiative with potential for saving the Navy nearly \$15 million a year and 2.7 million lost man-hours by preventing unintended pregnancy and keeping active duty women mission ready. Operation PINC will celebrate this successful advancement in military medicine with a grand opening ceremony on May 3, 2016.

2016 Navy and Marine Corps EMDP2 Selections Announced

Please join Navy Medicine and The Uniformed Services University in welcoming the FY 16 Enlisted to Medical Degree Preparatory Program (EMDP2) class. Five sailors and one Marine will be starting the program in August. Navy Medicine would like to extend a warm welcome to these outstanding individuals who were chosen from a very competitive pool of applicants. The selectees will be joined by five Army and five Air Force colleagues at a welcome ceremony on the USU campus later this summer. BUMED is currently preparing to receive applications for the Navy and Marine Corps FY17 EMDP2 class. Please see <https://www.usuhs.edu/emdp2> for program information, eligibility requirements and application instructions. Contact LCDR Jami Peterson at jami.j.peterson.mil@mail.mil with any questions.

Navy Selectees:

HM2 Hanyuan Liu
HM2 Emily Poe
CT1 Michael Smith
HM2 Nicholas Toufexis
MM1 Chrystopher Young

Marine Selectee:

SSGT Dwayne Smith



Wellness Beyond Cancer

By LCDR Jessica Shank, MD, Department of Obstetrics & Gynecology, Naval Medical Center San Diego

SAN DIEGO, CA - As the U.S. population ages, cancer screening increases, and cancer treatments improve, millions more Americans will be classified as cancer survivors. As the number of woman cancer survivors increases, quality of life, including issues of sexual function and vaginal health, will require more attention.

Although the normal aging process prompts physical changes that influence sexual function and vaginal health, including vaginal atrophy after menopause, cancer and its treatments can compound these issues and induce symptoms earlier. These changes also cause pain with intercourse in some women and consequent loss of sexual desire. Estrogen deprivation and menopause triggered by cancer treatment is typically abrupt, with more intense and prolonged symptoms, including hot flashes, vaginal dryness, and dyspareunia. When women are treated for cancer with surgery, pelvic radiation, chemotherapy, and/or endocrine therapies such as aromatase inhibitors, vaginal atrophy is often more severe. Not only gynecologic cancers, but also breast cancer and colorectal cancer are common diagnoses that are treated with therapies that affect ovarian function.

Additionally, health professionals have limited professional knowledge to respond effectively to the sexual concerns of patients. Many healthcare providers frequently hold the incorrect perspective that sexual matters are not relevant to the treatment process.

In a study published in January 2015, data from clinical assessment forms were extracted from 509 women referred to the Female Sexual Medicine and Women's Health Program during and after cancer treatment. Of note, 44% of patients experienced

pain during their exam. Ninety-three percent were somewhat to very concerned about sexual function and vaginal health. Approximately half had moderate to severe dryness and pain with sexual intercourse and 93.5% had an FSFI score <26.55, suggesting sexual dysfunction.

Another cohort study published this year enrolled 304 premenopausal, sexually active women diagnosed with early stage breast cancer. Questionnaires were completed, and sexual activity was measured at two time points: after surgery and then at least 12 months after the completion of chemotherapy or endocrine therapy. Among the 269 women who remained sexually active, one third were currently experiencing sexual dysfunction, which was significantly higher compared with the frequency before diagnosis. Chemo-related menopause was found to be a significant risk factor for sexual dysfunction.

In an effort to improve the quality of care of cancer patients and survivors at Naval Medical Center San Diego (NMCS), Drs. Kerrie Adams and Jessica Shank of the Department of Obstetrics and Gynecology created the "Wellness Beyond Cancer Clinic (WBC)". The Wellness Beyond Cancer clinic was created to address quality of life issues and to improve the quality of care of women cancer patients and survivors at NMCS. The clinic consists of a multi-disciplinary team of health care providers including Female Pelvic Medicine and Reconstructive Surgery, Gynecologic Oncology, Physical Therapy, Social Work, and Psychology. Together our health care team addresses the unique physical and emotional needs of patients coping with symptoms of cancer treatment and transitioning away from "fighting cancer" to "surviving cancer."

A Critical Specialty You May Not Have Heard Of

by CAPT Amy Gavril, MC, USN

During my Child Abuse Pediatrics Fellowship I was shocked and dismayed to learn that most experts in my field consider having a parent in the military to be a risk factor for child abuse. As both a US Navy officer and a mother, I was offended. However, I learned this concept is not due to misunderstood bias in the civilian medical community but on decades of research. For instance, two independent studies showed that military children are about 3.5 times more likely to be victims of inflicted head trauma than civilian children (Keenan; Gessner & Runyan).

A study from North Carolina suggested that military children less than 10 years old have twice the homicide rate of their civilian peers; in the <10 age group, homicides are almost always due to fatal child abuse. The reality is our military population is distinctly different from the civilian one. It's not all bad news though- in times of low military operational tempo, the military child neglect rate is half that of the general population. All those services offered to military families really do pay off! What the child abuse medicine world learned in the early 2000's however, is that when military operational tempo rises dramatically, so does the child maltreatment rates of military children. Here at the Armed Forces Center for Child Protection we consulted on some of the most severe maltreatment cases the staff



had ever seen and the referrals multiplied during this time frame. We care for a unique population and we must continue to work toward a better understanding of this uniqueness in order to improve the care of our military families.

Child Abuse Pediatrics is the newest board certified subspecialty in Pediatrics. Currently, there are 2 fellowship trained, board certified active duty child abuse pediatricians in the USN- LCDR Sarah Villarroel and me, CAPT Amy Gavril. LCDR Villarroel is stationed on Naval Medical Center San Diego and I am assigned to the Armed Forces Center for Child Protection, a division of the Department of Pediatrics at Walter Reed National Military Medical Center Bethesda. Together, we are available to assist professionals locally and remotely with cases of possible child maltreatment.

Our mission is a truly joint one.

We are joined by 1 Air Force and 1 civilian child abuse pediatrician to offer coverage and consultation throughout the entire DOD in this specialty. A common misconception is that child abuse pediatricians only know how to make one diagnosis – abuse. This is actually quite inaccurate, given that child abuse pediatricians rule out abuse and identify alternative causes for their patient's medical findings about a quarter of the time. It is sometimes assumed that a child abuse pediatrician is consulted only after a case of abuse or neglect has been clearly identified but in truth, child abuse pediatricians are much more useful when they are involved sooner in the care of a patient than later. A physician pursuing a child abuse specialty must first complete a three year pediatric residency. The child abuse fellowship is 3 additional years and includes extensive study in the biomechanics of injury and “medical mimics” of physical abuse, sexual abuse, and neglect, as well as forensic medicine and testing, legal and law enforcement policy and programs, multidisciplinary team functioning, expert witness testimony, and specialized interviewing and examination techniques. LCDR Villarroel and I are available to assist whenever concerns for possible child sexual abuse, physical abuse, neglect, psychological maltreatment, child homicide, or child trafficking exist.

LCDR Villarroel and I spend much of our time reviewing cases

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Critical Specialty (Cont.)

from all over the DOD for law enforcement agencies such as NCIS and writing medico-legal case reports giving expert opinion on abuse or neglect likelihood. We also evaluate local military children when there are concerns of possible abuse or neglect. The majority of our time is assisting other MTFs with possible abuse work ups, locating the right local professionals to perform certain evaluations or tests, and assisting in communication with other programs such as law enforcement, child welfare services, family advocacy program, and JAG for possible courts-martial. Our Commands are kind enough to allow us to assist as medical consultants and expert witnesses in DOD courts-martial and we work frequently with prosecution as well as defense teams – whichever team asks for our services first. One benefit to this inter-professional teamwork is a cost-savings to the DOD; outside expert consultants for courts-martial can cost tens of thousands of dollars. In addition, by making our services available to the legal system, other medical professionals are less likely to be pulled away from their MTF practices to testify. We are available for consult 24/7; a consult can be a simple curbside chat to a formal written report, whatever fits your needs.



To contact me, CAPT Amy Gavril: **Office: 301-319-7769**
Text or call my cell: 210-260-4421
Amy.r.gavril.mil@mail.mil

If your MTF is in the Pacific I am the child abuse consultant on the PATH secure communication system. When all else fails, the Pediatric Residents at WRNMMC can always find me or one of the other AFCCP professionals: Senior Resident Phone **301-676-7337 (PEDS)**.

If you are in the San Diego or west coast area, LCDR Villarroel can be contacted by **sarah.a.villarroel.mil@mail.mil** or **619-532-7079**.



Confessions of an Emergency Medicine UMO

by LCDR Anthony Bielawski, MC, UMO

Although Emergency Medicine may have a reputation for “Treat ‘em and Street ‘em” approach to patient care, opportunities for a little continuity of care arise from time to time. This is one of the many rewarding experiences I have enjoyed over the last year during a Full-Time-Out-Service (FTOS) Fellowship in Undersea and Hyperbaric Medicine at the University of California San Diego (UCSD). This unique opportunity is available to all Undersea Medical Officers (UMO) regardless of primary specialty with follow-on orders to the Undersea Medicine Community after fellowship completion. Most think of Hyperbaric Medicine as treating only SCUBA divers, but a much broader net of patient care exists within the Hyperbaric Medicine Specialty. Most of our daily hyperbaric treatments include tissue healing from delayed effects of radiation, burns, and complex wounds. These are just a few of the many proven indications for Hyperbaric Oxygen Therapy (HBOT). But unlike most of my Emergency Department interactions, our patients return daily for four to eight weeks to complete their therapy. With each treatment lasting nearly two hours every day for one or two months, we refer to our patients as having a



Critical Care Hyperbaric Chamber Treatment in Progress

“part-time job” with us. This allows lasting interactions between our patients and the medical staff. I have thoroughly enjoyed building these patient bonds in my fellowship time at UCSD.

But my time is not without a little medical excitement either. There are the fair share of middle of the night carbon monoxide poisonings, SCUBA dives gone wrong, and iatrogenic gas embolism saves. It is very rewarding to learn how to treat a critical care pediatric patient with ventilators, IV pumps, monitoring, and sedation, all while in a hyperbaric chamber. But “My Confession” and the most memorable part of my fellowship are the patient relationships; I became a part of my patients’ lives and they became a part of mine. If you are looking for a rewarding medical experience or just a way to expand your UMO knowledge then consider the Undersea and Hyperbaric Medicine Fellowship. It has been without a doubt one of the best and most rewarding experiences of my Navy career.



LCDR Bielawski participating in Dive Research during Fellowship"

How Valuable is a Military Pension?

by CDR Joel M. Schofer, MD, MBA, CPE, FAAEM, ER Specialty Leader

Two recent events led to this article. First, an article about becoming a multimillionaire in the military appeared on military.com (<http://www.military.com/money/retirement/military-retirement/can-military-service-make-you-a-millionaire.html?ESRC=!nance.nl>). Second, I was having a discussion with some other officers about this topic and they thought my opinion on the subject was different from what they had heard before. Because of this, we're going to examine the value of a military pension.

How Much of a Pension Do You Get?

Let's look at two likely scenarios for a physician. First, someone who stays in for 20 years and retires as an O-5. Second, someone who stays in for 30 years and retires as an O-6. Their pensions in today's dollars would equal approximately:

- 20 year O-5 = \$4,102.50/month or \$49,230/year
- 30 year O-6 = \$8,053.50/month or \$96,642/year

SOURCE: <http://militarypay.defense.gov/Calculators/ActiveDutyRetirement/High36Calculator.aspx>

Remember that your military pension payments are adjusted annually for inflation, a very valuable benefit

How Much is This Worth?

The easiest way to answer this is to examine the pension and figure out how much money you'd need to have invested in order to pay yourself exactly the same amount of money inflation adjusted for the rest of your life. Unfortunately, this is not a simple issue.

Military.com Article "Can Military Service Make You a Millionaire?"

The aforementioned military.com article states, "The Defense Department puts the value of the monthly check of an O-6 retiring today with 30 years of service at \$2.2 million...The DoD made a number of assumptions, but the idea was to put a price tag or value on the monthly military retirement check a military retiree will receive." This article doesn't go into the assumptions made, but let's just take it at face value.

My MBA Finance Professor

In 2013 when I was taking my MBA, I asked my Finance professor how he would value a 21 year O-6 pension, another common circumstance for a physician. At the time this pension was approximately \$53,400/year. Here is what he said: "If you looked at this as an 'endowment' where one would not spend the principal, then take the annualized benefit \$53,400 ($\$4,455 \times 12$) and divide by a long-term rate such as the 30 year Treasury bond rate (3% in 2013) to get \$1,782,000. In other words, if you had that \$1,782,000 and put it all into 30 year Treasury bonds at 3% you would get your \$4,455/month. Of course, the issue is whether the 3% is a good number for the long-term. If, however, you were to look at this as an 'annuity' where you would spend down the principal until time of death, then you have all sorts of demographic stats issues (e.g., expected life after retirement, future interest rates, variability of the annuity investment, cost of living adjustments, etc.). In a nutshell, it can get quite complex. There are a number of websites available often through reputable firms such as Fidelity, Vanguard, etc., that

you can perhaps access that have such calculations available already (instead of having to create your own model). You can plug in your what if's and see what pops out."

Using the 30 year Treasury bond rate from 3/18/16, which was 2.68%, here is the valuation with his methodology:

- 20 year O-5 = $\$49,230 / 2.68\% = \$1,836,940$
- 30 year O-6 = $\$96,642 / 2.68\% = \$3,606,044$

The problem with this analysis is that a regular 30 year Treasury bond is not inflation adjusted, so in my opinion you'd have to compare it to TIPS (Treasury Inflation Protected Securities). A recent yield on a 30 year TIPS is 1.12%, which would value the two pensions we're considering at:

- 20 year O-5 = $\$49,230 / 1.12\% = \$4,395,536$
- 30 year O-6 = $\$96,642 / 1.12\% = \$8,628,750$

Keep in mind that the lower the Treasury bond yields go, the more valuable your pension is because you'd have to invest more money to get the same payout. Since today's Treasury yields are at historic lows, these valuations are probably as high as they'll ever get.

Annuity Websites

If you go to annuity websites and try to purchase an annuity for these two amounts, here is how much they would cost:

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Military Pension (Cont)

Fidelity Guaranteed Income Estimator (<https://gie.fidelity.com/estimator/gie/gielanding>):

For a 20 year male O-5 who is 50 years old, lives in Virginia, and wants to earn \$4,103/month or \$49,236/year with a 2% annual income increase (somewhat equivalent to the inflation adjustment of your military pension) the pension would cost \$1,322,826.

For a 30 year male O-6 who is 60 years old, lives in Virginia, and wants to earn \$8,054/month or \$96,648/year with a 2% annual income increase (somewhat equivalent to the inflation adjustment of your military pension) the pension would cost \$2,103,257.

The 4% Rule

The 4% rule is a commonly accepted retirement “rule” that says you can take 4% out of your retirement nest egg every year, annually adjusted for inflation, and never run out of money. In other words, for every \$40,000/year of income you need in retirement, you need to have \$1 million saved for retirement. Whether the 4% rule is valid in today’s low yield environment has been debated, but let’s just assume it is still valid (because I think it is). If you divide the annual military pension by 4% it would give you the size of the nest egg you’d need to withdraw that amount:

- 20 year O-5 = $\$49,230 / 4\% = \$1,230,750$
- 30 year O-6 = $\$96,642 / 4\% = \$2,416,050$

Keep in mind that your government pension is guaranteed by the federal government but the assets used in the typical application of the 4% rule, like your retirement accounts and other

assets, are not, making your pension a much safer bet that is probably worth more than the numbers above.

Unquantified Value

There is some value in the military pension that people tend to underestimate. First, it is guaranteed by the US government, which makes it “risk free.” The only option discussed above that would offer this same security is the valuation comparing the pension to Treasuries. Even an annuity from an insurance company is not risk free because insurance companies do go out of business. (I will admit, though, that this is a rare event, and you could diversify by purchasing annuities from multiple companies, so an annuity can be pretty close to “risk free.”)

Second, you can’t screw it up. Investors are their own worst enemy. They buy high, sell low, trade too frequently, don’t save enough, over estimate how high their returns will be, pay excessive investment fees, and make other errors that can very easily mess up their well planned retirement. You can not screw up your military pension.

Third, some states don’t tax a military pension. You can find that info on-line (<https://www.veteransunited.com/life/military-retirement-income-tax/>) or in PDF form (https://mccareer.les.wordpress.com/2016/03/statereport_4web.pdf).

Fourth, and this benefit is HUGE for me. I see my military pension as equivalent to a massive pile of TIPS. This allows me to take much more risk with the remainder of my investment portfolio and net worth. How much risk? Overall my asset allocation is 90%

in stocks, which is a lot more risk than most people would recommend at my age of 40. Because of my pension, though, I don’t think I’m taking too much risk.

The Bottom Line

As you can see, a military pension is risk free, inflation adjusted, and can be quite valuable. Can you make more money as a civilian, save well, and accumulate even more than this? Yes, but this is all determined by your civilian salary, discipline as an investor, and rate of return on your investments, which no one knows since they can’t predict the future. A military pension is a very valuable and underappreciated financial asset that is probably worth somewhere between \$1,200,000 and \$2,500,000, depending on how long you stay in and what rank you achieve. If you try to match the risk with inflation adjusted Treasury bonds at today’s rates, it is worth a lot more.



Naval Academy Medical Corps Selectees Enjoy Dinner with Senior Leaders

As another academic year comes to a close at the United States Naval Academy, the graduating class (or First Class) of Midshipmen find out what their final service selection will be for their U.S. Naval careers. After the service selection ceremony, each of the Navy's service communities (Surface, Aviation, Submarine, Marines, etc.) welcomes the new graduates with community specific events.



The Medical Corps selectee dinner was held at the Buchanan House on February 29th and was graciously hosted by Vice Admiral Walter E. "Ted" Carter, Jr. the 62nd Superintendent of the Naval Academy. Vice Admiral C. Forrest Faison, III, (Surgeon General and Chief of the Bureau of Medicine and Surgery) was the guest of honor and was joined by Vice Admiral Raquel C. Bono (Director of the Defense Health Agency), Rear Admiral (select) Paul D. Pearigen (Chief of the Medical Corps), CAPT M.B. McGinnis (Commanding Officer of Naval Health Clinic Annapolis), and Colonel Stephen Liszewski (Commandant of Midshipmen at United States Naval Academy), along with other distinguished Officers from Naval Health Clinic Annapolis.

This year the Naval Academy selected 15 highly qualified Midshipmen, including a Rhodes Scholar, to represent the Academy in Navy Medicine's Class of 2020. VADM Carter noted that selection for the Medical Corps was the most competitive of all Navy service communities.

The night was spent with good company and great food. Vice Admiral Faison spoke, welcoming the class and had a special awards ceremony where he gave each of the Midshipmen their first Medical Corps insignia. The night came to a close with congratulations, encouragement, and camaraderie that will continue to grow during the Midshipmen selectees' future Navy Medicine careers. They were charged by the Surgeon General with becoming the best Naval Officers and physicians that they can, and to always place the patient first.

Embedded Psychiatry - Mental Health Support on the Frontlines

by CAPT James Reeves, Psychiatry Specialty Leader

A cool spring breeze refreshed the soldiers in their trenches during a respite after some long hard fighting in 1914. Suddenly one of them declares: 'There's a sort of greenish, yellow cloud rolling along the ground out in front, it's coming ---.' Every soldier quickly dons their masks and readies for the incoming attack, but no attack comes and few are impacted by the gas. The next few days soldier after soldier reports to the medical aid station with respiratory symptoms. As the first soldiers are sent to the rear, more report with symptoms and are sent to the rear until a flood of referrals develops. The Division psychiatrist quickly realizes what is going on and develops a system to reassure these soldiers at the front lines and the flow of men with symptoms quickly tapers off over the next few days. "War Psychiatry" Ed Franklin Jones 1985 Office of the Surgeon General of the US, Empey, Arthur Guy, Over The Top (1917); Lloyd, Alan, The War In The Trenches (1976).

This description of how embedded psychiatrists can quickly understand the nature of the warfighter's problem and devise eloquent solutions to preserve the fighting force has withstood the test of the last 100 years of war. Although the nature of fighting, and the descriptions of mental health sequelae have changed, the importance of having a psychiatrist readily available to help members in need has not.

The Marine Corps understood this in 2003 as fighting in Iraq began to escalate. The Navy's Bureau of Medicine and the Marine Corps implemented the

Operational Stress Control and Readiness (OSCAR) program to put psychiatrists at the Regimental level seeing Marines at the Regimental Aid Station so Marines do not have to traverse long distances and take valuable time away from their unit to receive mental health support. These OSCAR psychiatrists began working with the Battalion Commanders and the Marine NCOs to assure that Marines in need had the best opportunity to recover. They proved to be very valuable in OIF and helped develop programs like Warrior Transition for Marine units.



LCDR Treadwell, psychiatrist at USNH Yokosuka meeting with the CDR Graham, CO of USS JOHN S. MCCAIN

OSCAR has allowed psychiatrists to become trusted members of the Marine command applying their distinct perspective as trusted counsel on a myriad of command decisions with a psychological dimension. These officers wear the Marine uniform, learn to speak the language and are frequently seen alongside the Marines at command activities. They understand the nature of stress facing Marines and learn to decrease stigma and open doors to care that were previously

closed. While OSCAR psychiatrists will treat individual Marines, they also have a wider understanding of issues facing the Marine Corps and facilitate innovative solutions to large scale problems such as developing Force Preservation Councils in Marine battalions. The Force Preservation Councils have become an important tool which battalions use to assure Marines are getting the help they need so they can remain a Marine. The 3rd Marine Division OSCAR team has developed a Tactical Resiliency Course which commanders have come to rely

on as way to help their Marines who are experiencing behavioral problems. The course is designed for infantry Marines by an OSCAR provider who knows precisely what the issues are for these Marines. These lessons point to the importance

of moving uniformed psychiatrists away from the traditional Navy clinic and embedding them into operational units where they can best serve the force.

This model has since been moved into the Fleet Surgical Teams where psychiatrists have reduced the number of psychiatric medevacs off ships during an Expeditionary Strike Group by 42-63%. An embedded psychiatrist with Submarine Squadron 6 has reduced unplanned psychological losses by 77% and Emergency Psychiatric Visits by 90%, saving

Embedded Psychiatry - Continued

nearly \$50 million in lost personnel costs. Employing a team/family approach to caring for sailors that actively involves the spouse and command leadership has resulted in a significant cultural shift from “expendability”, to one of “personnel investment and care”. The cultural change (i.e. improvement in resilience) is reflected in the highest people-centered assessment scores in the Submarine Force; this people-centered assessment representing the degree to which units' command climates support Sailors flourishing. This profound level of trust has led to a request for the first Force Psychiatrist, an Executive Leadership Coaching Program for prospective Commanding and Executive Officers, and finally expansion of the embedded mental health program across the Navy.

Psychiatrists have become integrated into SOCOM and frequently deploy helping SEALs around the world. SOCOM psychiatrists have been instrumental in enhancing force readiness and optimal performance by providing preventive education on insomnia and effective sleep management. They have also been crucial for identifying service members with emotional and/ or cognitive issues related to repeated concussions, alcohol use, sleep apnea or chronic sleep deprivation which might have otherwise been missed or misdiagnosed and treated for stress related problems.



Psychiatrists, CDR Richter, LCDR Burger, and LCDR Penn serving in the 1st Marine Division

Psychiatrists at MTFs have begun applying these lessons and taking mental health care from the hospital to the pier side. Identifying a need on the waterfront for shipboard mental health services similar to those seen on the carrier, leaders at USNH Yokosuka's mental health department worked with leaders at DESRON 15 to send social workers, psychologists and psychiatrists to 6 different ships. These providers assist with direct patient care seeing sailors for therapy and medications on board, have direct access to commands for administrative recommendations, teach corpsmen how to better assess and manage mental health concerns while afloat, work with departments and the Chief's Mess to discuss mental health related topics and are a direct liaison to the hospital should sailors require acute evaluation. Their presence increases access, cutting time off work and decreases stigma by integrating with the crew.

Psychiatric care is unique among medical specialties in that it is based entirely upon the willingness of the patient to trust the doctor and provide accurate information, and for the doctor to understand the

distinct needs of the patient. Barriers at the MTFs can erode our ability to provide informed and useful psychiatric care. Sailors can find it difficult to be seen at the MTF (parking, time off work, stigma of being in a psychiatric clinic) leading to high no show rates for mental health. Also, psychiatrists at a MTF are removed from understanding what life is

like for Sailors/Marines. They approach clinical problems from a textbook perspective not understanding the unique cultural distinctions of what is normal and how to handle problems in the Fleet. This lack of knowledge makes them blind to understanding the real issues facing their patient and how to best solve them. Psychiatrists who are integrated with the operational forces and trusted by their line officers have a much better chance of providing the care needed in today's highly specialized Navy and Marine Corps. Navy psychiatrists will continue to push our specialty to provide embedded care in operational forces with a high need for mental health care. We know this will lead to improved outcomes for the individual in need as well as the force as a whole. We believe this gives us the best chance to decrease the stigma associated with mental health care, best address related issues like suicide in the Fleet and provide better informed policies that help us retain our Sailors/Marines and keep the force healthy.

FY17 CAPT Board Convening Order Deconstructed

Joel M. Schofer, MD, MBA, CPE, FAAEM
CDR, MC, USN, EM Specialty Leader

The FY17 Staff Corps O6 Board Convening Order (<http://www.public.navy.mil/bupers-npc/boards/activedutyofficer/06staff/Documents/FY-17/FY-17%20AO6S%20CONVENING%20ORDER.pdf>) was released after conclusion of the board. The best news was that the promotion opportunity for Medical Corps was 70%, up from 50% last year, which was an all-time low. Aside from that, though, if you read through the convening order, it basically tells you how to get promoted to Captain. I've read through it and pulled out quotes that you can turn into actionable items:

"Their personal and professional attributes include...physical fitness..."

ACTION ITEM: Workout and never allow yourself to fail a PFA.

"...successful performance and leadership in combat conditions demonstrate exceptional promotion potential and should be given special consideration."

"The board may give favorable consideration to those officers who have displayed superior performance while serving in IA (Individual Augmentee)/GSA (Global Support Agreement)/OCO (Overseas Contingency Operations)/APH (Afghanistan-Pakistan Hands) assignments that are extraordinarily arduous or which involve significantly heightened personal risk."

"Success in these assignments [joint duty assignment billets] should be given special consideration..."

"Navy Medicine needs leaders with knowledge and experience in a variety of settings including operational medicine, joint medical operations, and current peacetime health care delivery initiatives."

"Navy Medicine greatly values joint experience..."

"You must ensure that Navy Medicine's future leaders possess the broad knowledge necessary to support the operating forces and are acknowledged leaders within their operational...specialties."

"The officers selected must have demonstrated exceptional managerial skill and professional competence in executive and staff roles both in support of the fleet and Marine Corps and within the naval shore establishment."

"...you should select those officers who have served in a broad spectrum of assignments requiring expertise in diverse functional areas."

"...those you select will be placed almost assuredly in positions that require broad military and medical perspectives beyond the

Department of the Navy."

"Best and fully qualified officers for the rank of captain, will be those who have demonstrated experience and expertise across the spectrum of military treatment facilities, operational platforms in support of the fleet or the Marine Corps, and the intersection with the strategic and tactical issues in provision of military healthcare through experience in headquarters or other associated DoD agencies."

ACTION ITEM: Deploy, preferably in a combat or joint environment, if available. PCS when you can, and take a variety of assignments, including senior operational positions and positions with other services.

"The board shall give favorable consideration to those officers with relevant graduate education...and Navy and Joint Professional Military Education (JPME)."

"The Navy values completion of graduate education and development of a subspecialty. Degrees from the Naval Postgraduate School, the Naval War College and equivalent Service institutions, and civilian education programs...are desirable."

"Navy Medicine greatly values...formal education to include JPME I."

"The Navy values completion of graduate education and development within and officer's subspecialty."

ACTION ITEM: Get a masters degree, do a fellowship, or do JPME I and/or II.

"The Navy values competitive scholarships and fellowships, examples of which include: Olmsted Scholar, Marshall Scholar, Rhodes Scholar, White House Fellowship, SECDEF Corporate Fellowship, and Federal Executive Fellowships (e.g., Politico-Military and Cyber)."

ACTION ITEM: Consider applying for one of these scholarships or fellowships.

"Duty or service in combined or other staff positions at the senior levels of government should also be considered favorably."

ACTION ITEM: Don't be afraid to take positions in senior levels of government organizations when they are available.

"You shall give consideration to an officer's clinical and scientific proficiency as a health professional to at least as great an extent as you give to that officer's administrative and management skills. Strong consideration should be given to board certification when a board certification exists for the specialty."

ACTION ITEM: Get and stay board certified.

Cutaneous Oncology at Walter Reed National Military Medical Center

by Anis Miladi, MD, FAAD

LCDR, Navy Dermatology Specialty Leader

The Cutaneous Oncology Clinic at WRNMMC continues to improve and expand to serve our Active Duty Military and Tricare eligible patients. The clinic, working in concert with the Murtha Cancer Center, is actively seeking new consults for patients from anywhere within the Department of Defense. Any and all types of skin cancer are treated, to include but not limited to, melanoma, merkel cell carcinoma and cutaneous T-cell lymphoma. In addition to the Moh's Micrographic Surgery Clinic, which

performs several hundred cases per year, the Pathology Department has five practicing Dermatopathologists as well as full access to the consultative services of the Joint Pathology Center (formerly the Armed Forces Institute of Pathology) with its decades of expertise. Both the Dermatopathology and Moh's Departments already accept consultations and patients (respectively) from around the world. A new addition to the Dermatology Clinic includes a

recently acquired semi-automated total body imaging system (see photo attached) to assist in monitoring patients pigmented lesions.

Patients enrolled in the Cutaneous Oncology Clinic at WRNMMC receive multidisciplinary care with services including Radiation Oncology, Diagnostic Radiology, Dermatology, Medical Oncology, Surgical Oncology and Ear, Nose and Throat Surgery. A Nurse Case Manager, Ms. Merlene Robinson, is now available to assist with the management of referrals to Cutaneous Oncology at WRNMMC. Please feel free to contact her with any questions regarding patient referrals or patient management. Her direct line is 301-295-0138, or she is also available through email at merlene.n.robinson.ctr@mail.mil. If your inquiry is more medical in nature, please feel free to contact Lieutenant Commander Nicholas Logemann, Director of the Cutaneous Oncology Clinic, at nicholas.f.logemann.mil@mail.mil. We look forward to working with you in caring for our patients.



HN Garrison operating the total body imaging system at Walter Reed NNMC Dermatology Clinic. On the screen are demonstrated the various poses the patient performs to ensure complete body imaging.



Female Physician Leaders Gather at DHHQ this Spring

The 2016 MHS Female Physician Leadership Course was attended by over 100 female physician leaders from Military Treatment Facilities all over the world. The attendees were competitively selected from a pool of nominees and represent future leaders in military medicine. The Council for

Female Physician Recruitment and Retention sponsored the 2 ½ day event held at the Defense Health Headquarters, April 11-13, 2016. The attendees participated in formal lectures, panel discussions, group activities and workshops focused on developing effective leadership skills.

One attendee described the course as “career changing.” This course will continue to be an annual event for female physicians in the Air Force, Army, Navy, Public Health Service and Uniformed Services University students.



VADM Bono fields questions and shares experiences at the 2016 MHS Female Physician Leadership Course



Navy Medicine attendees take time for a picture

Navy Medicine Participates in 2016 Conrad Foundation Spirit of Innovation Challenge Summit

Navy Medicine had a presence at the 2016 Conrad Foundation Spirit of Innovation Challenge held at the Kenney Space Center April 20-24, 2016. This event showcases young entrepreneurs and their innovative solutions to a variety of problems in a competitive, yet collaborative, environment. Competitors are referred to as “Diplomats” and this year’s Challenge featured 332 Diplomats from 20 states and 16 countries. LCDR Jami Peterson participated as a judge for the Health and Nutrition category during this event. In addition to the competition, the Summit also provided multiple educational exposures and discussion sessions for learning and networking. Navy Medicine also provided information on career mentorship and available career opportunities within the Navy. LCDR Peterson described the Diplomats as, “an exceptionally bright and energetic group of young people, who, without a doubt, will have a significant impact on the world.”



LCDR Jami Peterson judging the Diplomats’ 6 minute “Power Pitches”



Nancy Conrad, founder of the Summit, discusses the event with Robert Cabana, Director of NASA and CAPT David Bouve, Director of Marketing and Advertising for the U.S. Navy

News From the Detailers

Order Delay

Order release has been delayed this year causing understandable angst. This is unfortunate as many things that a move entails, such as moving your household goods, cannot be initiated without released orders. This general delay is secondary to funding. It is also frustrating when peers, detaching at similar times, get orders released at different times. This IS NOT because detailers are showing favoritism and pushing certain orders through. A variety of factors can lead to varied order release times. OCONUS, operational, no-cost, and new-accession orders are prioritized. Considerations, including active duty colocation and exceptional family member status, can also delay orders. PERS will get orders released as fast as possible. Our goal is to have them released greater than 60 days prior to detach month. Thanks for your patience.

Survey

Navy Personnel Command is in the process of modernizing the

billet assignment process. As part of this effort, summer 2017 Emergency Medicine billets will be assigned using a match mechanism similar to the civilian residency match. To gain insight into current perceptions about billet assignments among medical corps officers, we are administering a survey this spring. Please consider completing it; it will take less than 10 minutes. Look for it in your inbox soon.

New Personnel

This summer, we will have two new medical corps detailers. CAPT Anthony Battaglia will be replaced by CAPT Nanette Rollene as the senior medical corps detailee, in charge of executive medicine and surgical specialties. LCDR Kayreen Gucciardo will replace LCDR Deepak Devasthali as the GMO and GME detailee. Look for updated contact information on milSuite this summer.

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.



**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 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

NAVY MEDICINE ON THE WEB

<http://www.med.navy.mil>

<http://navymedicine.navylive.dodlive.mil>

Navy Medical Corps Challenge Coins

High-quality 1.75" coin with classic front and contemporary back, a wonderful memento, gift, or token of appreciation:

Suggested donation:

\$8/coin

+ postage

(varies by weight & zip code)



Due to high demand and shipping logistics, orders are capped at a 10-coin maximum.

Please email CAPT Greg Thier <gregory.thier@med.navy.mil> with the following information:

- **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).

All donations go to Medical Corps Birthday Ball Committee

MC Coffee mugs available now



Suggested donation

\$8/mug + shipping

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

All donations/proceeds to go towards Medical Corps Birthday Ball