Medical Corps Newsletter

SUMMER 2019

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From the Corps Chief...

RDML Paul D. Pearigen
Chief, Medical Corps

It is with unsurprising sadness that I write this, my final, Medical Corps newsletter article as your Corps Chief. It has been the privilege of a lifetime to represent the active duty physicians of our United States Navy for these last three-and-a-half years. Each of you individually, and collectively, have my profound respect, my enduring appreciation, and my sincere best wishes for what lies ahead.

My closing admonition in this time of extraordinary change and undeniable challenge is to remain personally true to the tenets of the Navy physician that I have espoused throughout my tenure: professionalism, compassion, service, and leadership.

In military medicine, we have the privilege of operating alongside a broad spectrum of highly trained and remarkably dedicated colleagues bringing expertise in nursing, clinical support, logistics, planning, corpsman technical ratings, not to mention the warfighters of the line Navy, Marine Corps, and joint service. They are each professionals in their own right—and they deserve the highest in professional manner, ethics and behavior from the physician members of these teams. **Professionalism** means a commitment to standards in a unique field of expertise, advancement of specialty knowledge, self-management as a community, recruiting and developing those who come behind us, enthusiastic life-long learning, and serving the greater society with our particular abilities.

As many of you have heard me say, Navy physicians cannot leave **compassion** to our nursing and pastoral colleagues, as deeply capable as they prove themselves to be on a daily basis and in the most difficult of settings. While our patients—whether on the battlefield, in sickbay, or in the medical center operating suite—most certainly count on their physicians to be the pinnacle of medical knowledge, technical skill, and integrative intellectual decision-making, I firmly believe that the Sailor, Marine, family member or retiree in your care looks to their doctor to also be a caring, understanding, and empathetic healer. Don't abdicate your humanity to the rest of the care team. You are the head of that team.

While **service** to Nation, shipmate, and our Navy & Marine Corps was undeniably an element of your decision to put on the uniform, the many distractions, challenges, and temptations we encounter over the course of our careers bring a risk of losing sight of the service calling that underpins who we are as physicians and Naval officers. Life gets complicated; family calls; resource shortfalls dishearten; deployments are long or frequent (or both); general fatigue and physician burnout can ensue—with appreciation and fulfillment sometimes elusive. Remember the joy in your calling and the sacred nature of your talents. Seek out that joy for others and renew your colleagues along with yourself.

Finally—and I do believe the last must come on the heels of the first three tenets to be credible—**leadership.** In particular, physician leadership. There is something particular about the way a physician can lead. Something about our approach to a problem, the sophistication of our analysis and effects understanding, and physician ownership of data-driven, compelling, and consequential solutions. While forces have seemed to erode the autonomy and authority once automatically attributed to physicians, there remains a tremendous respect and a need for physician intelligence, training, tenacity, sacrifice, gravitas, and even wisdom. We must be stewards of those traits and the respect they foster, and we must restore and renew the veracity of that respect in the health care arena, including within military health. That means staying true to values, integrity, and ethos in all our interactions—with patients, staff, colleagues, administrators, more senior leaders and line commanders. And it means being engaged and active in physician leadership. It means stepping up, not stepping back.

Thank you again for all that you have done and all that you have become. What's Next?

Readiness and the Reserves...

CAPT Jay Shirley
MC Reserve Affairs Officer

Reserve medical officers are answering the call. Since February 2019, seventeen (17) reserve medical officers volunteered for 23 twenty-three (23) individual augmentation (IA) requirements for operational contingency operations in OCONUS locations. All twenty-three requirements were filled and included critical specialties: general surgery, internal medicine, emergency medicine, anesthesiology, orthopedic surgery, and psychiatry. This group includes some considerably experienced physicians and surgeons such as the critical care/trauma fellowship trained surgeon who also completed an internal medicine residency, the thoracic fellowship trained surgeon, and the two critical care / pulmonary fellowship trained internal medicine physicians. Several have deployed before and for some this is the first operational assignment. They come from civilian practices that include major academic medical centers, busy trauma centers, hospitals, and practices.

We recently selected a busy clinician to fill a critical leadership position as Deputy Joint Task Surgeon GTMO. He brings leadership experience from his civilian work and he was also previously a commanding officer of a reserve EMF and held critical post-command positions. The Navy Reserves have provided qualified and experienced officers in leadership positions such as this Deputy JTF Surgeon position as well as U.S. Marine Forces Central Command and U.S. Marine Forces Europe and Africa Force Surgeon positions for several years. Expeditionary Medical Units assigned to U.S. Central command in 2017 and 2018 were staffed and led primarily by the reserve component.

The call goes out for volunteers for critical mobilizations for Navy Medicine and usually almost immediately the emails starting coming in from those who want to volunteer. Some have valid questions about when, where, how long, what's the mission, etc. There are usually some that are not ready to raise their hand right now for good reasons. Maybe they just started or joined a new practice, their partner in practice will be out on medical/maternity leave, or they have ill family members, etc. The answer maybe that now is not the best time but they volunteer for the next rotation and that often works better for all. The respective reserve component specialty leaders talk with individuals and sort out some of these issues and make recommendations regarding the best fit for the individual missions.

Reserve medical officers continue to show their value and commitment to serve on an ongoing basis at military treatment facilities (MTF). They have provided over to facilities based on validated requests from Navy Medicine East and West. In the fall of 2018, when the USNS Comfort deployed to SOUTHCOM, reserve medical officers provided over 475 man-days of service and were able to allow Navy Medical Center Portsmouth to continue provide needed services. The busy clinician that maintains quality standards and is focused on pa-

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OPERATIONAL OFFICER SPOTLIGHT

(Left to Right) LT Ian Porter, CAPT Rodderick Borgie, LCDR Dustin Wallace, Capt Sara Edwards (Army)
Credit: Kelli Mars, NASA

LT Ian Porter is a board certified Aerospace Medicine Specialist and recent graduate of the Residency in Aerospace Medicine (RAM Class of 2018) program in Pensacola, FL. His crew of four (which also included U.S. Navy CAPT Rodderick Borgie) recently completed a 45 day earth analog mission onboard HERA, NASA's Human Exploration Research Analog. The purpose of platforms like HERA are to assess behavioral health and performance, evaluate human factors, study communication, autonomy, medical capabilities, and biological markers with the hopes that someday this valuable data will contribute to our eventual success of getting to Mars.

"I found out about HERA during residency and also knew a U.S. Air Force flight surgeon who had previously done one of the earlier 30 day missions. I thought if I applied for the mission and got selected, it would be a tremendous experience in so many ways. I have always wanted to be part of something having to do with NASA. It is my specialty as a physician after all and what better way to get to know your community and specialty than to live it out here on earth representing the world's finest Navy."
HERA crew are research subject volunteers selected based on characteristics that are astronaut-like. While they are not astronauts, the expectation and demands of daily life in the HERA habitat are meant to mirror those experienced in isolation during a long term space mission. Challenges during mission include isolation, confined living spaces (less than 600 square feet total for the crew of four), decreased privacy

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OP-ED: Operationalizing Navy Medicine

Submitted by: Peter Roberts, CAPT, MC, USN
Fleet Surgeon, Commander US THIRD Fleet

Navy medicine has always been operationally oriented. It is our history and our mission. Current and past navy physicians have done tremendous things and saved countless lives on land, on and below the seas, and in the air. But things are changing and it is unlikely you've heard a senior leader speak in the last year without mention of change and acknowledgment of uncertainty. Though uncertainty brings anxiety, we believe there are opportunities and potential rewards in all change. Recently, Navy Medicine has focused on transitioning oversight of the medical benefit mission, without missing a beat in that care, while pivoting resources and attention to the operational forces. Concurrently all phases of Fleet operations have undergone significant changes of their own as we respond to national and global events. Third Fleet has been central to some of these changes.

As Commander Third Fleet (C3F) Surgeon I have been have been involved in "operationalizing" C3F. This has been a transition started by the prior Commander and seen to near completion under the current Commander, VADM John Alexander. When complete, COMPACFLT will have two fully operational fleets. This means two maneuvering units ready to deploy anywhere in the world's largest and busiest ocean for any reason. Part of this effort has been establishing a fully certified Maritime Operations Center (MOC) that is expeditionary and allows the entire Command to deploy with little notice from the comfort of San Diego to a ship or an expeditionary land based system. Not surprisingly, we call it "C3F Expeditionary." Regarding the change in mission and capability, VADM Alexander once commented, "…it's really not that hard. It's more of a culture thing than anything else." Once concerned primarily with homeland defense, training, maintaining, and evaluating warships prior to deployment, C3F now maintains operational control of missions well outside of traditional geographic boundaries and keeps constant watch over activities across the Pacific.

C3F staff have had to dramatically change their mindset, open their sight picture across wide activities and maintain focus on readiness while accelerating innovation. From the relative simplicity of personal individual medical readiness to an individual's role in the complexities of the MOC, it is anything but business as usual. Achieving this transformation while exceling at their traditional mission has been an achievement. It occurs to me that Navy Medicine will have to undergo a similar cultural change.

You've heard it before; a shift back to sea control from power projection (typically against less sophisticated forces) and new great power competition have made it clear the old way of doing things will be inadequate to meet the demands of the future. Current strategies will employ Distributed Maritime Operations (DMO). Though receiving much attention recently, DMO has been decades in the making. When the threats shifted from guns to missiles, the wider distribution of vessels was inevitable. The Aegis Combat System and other technological advances have allowed a large network of ships to become linked in detection of threats and be part of both offensive and defensive solutions. Disaggregation of surface groups are but a part of DMO and the overall effect will be that health support capabilities, along the entire "medical survival chain," will be widely distributed nodes of care. That's a game changer.

As the XO at the NATO Role 3 Hospital in Kandahar many years ago, I witnessed a relatively steady daily flow of casualties. These ranged from minor injuries to grievous multi-limb amputations, often dozens at a time. Deaths hit the unit hard because we saved most people. The casualties were typically not the result of a major battle or a

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and very tight schedules. "One of the things I realized in mission was how well trained and fortunate we are to be sailors as onboard ships and with the marines we are expected to live in confined quarters and to do more with less… I think my Navy background really helped make the transition from the outside world to confined isolation a smooth one. The applications of this really extended beyond the walls of HERA and to my family. They knew how to deal with time away from a loved one and I really think it benefited everyone being Navy when they opened those doors and congratulated us on a successful mission. I am very fortunate to have a family, a command such as Navy Medicine Operational Training Center (NMOTC), and a Naval Aerospace Medical Institute (NAMI) team that supported me and saw the value in such a rich experience that, I hope, will help with contribute our future missions in space travel." HERA continues with more missions, with three more missions remaining in this current campaign.

More information on HERA can be found on the NASA link: https://www.nasa.gov/analogs/hera

LT Porter reuniting with his daughter Gracie after the 45-day mission (it was also her 9th birthday).
Credit: Kelli Mars, NASA

Remembering the "82": A Look Back at our Navy Cross Physicians

André B. Sobocinski, Historian, BUMED

The Navy Cross is the second highest combat honor given to Navy personnel for "extraordinary heroism." Since February 4, 1919, when the award was first approved by Congress, a total of 82 Navy physicians have received the honor.

In August 1942, the criteria of the Navy Cross was changed limiting qualification to heroism "in connection with military operations against an armed enemy." Prior to this, several physicians were awarded the Navy Cross for actions during peacetime or non-combat operations.

LCDR Lee McGuire was a physician based at the Naval Hospital Chelsea, MA, in 1918 when the Influenza Pandemic hit. In 1919, he was awarded the Navy Cross for developing a "convalescent influenza-pneumonia serum" that reduced the mortality at the hospital from 38 percent to four percent.

CDR Lucius Johnson was awarded the Navy Cross in 1930 for his role as a first medical responder following the deadly Hurricane San Zenon which was estimated to have killed as many as 8,000 people. convalescent influenza-pneumonia serum, which has proved of very great value in reducing mortality from 38 to 4 per cent,

There have been seven posthumous Navy Crosses awarded to physicians. Among these was LCDR Edward Brown. On July 10, 1926, the Naval Ammunition Depot in Lake Denmark, NJ, was struck by lightning leading to the detonation of several million pounds of explosives. Brown led evacuation efforts and remained with casualties until he himself was over taken in the inferno.

CAPT Dinsmore (right) receiving the Navy Cross from GEN Westmoreland (left) in 1966

LT Henry Ringness had been a flight surgeon with Marine Air Group (MAG)-14 during the Guadalcanal Campaign in 1942. During an enemy attack, Ringness was injured by a mortar explosion that paralyzed him below the waist. Despite his injuries he dragged himself to administer morphine and blood plasma to other casualties. Ringness later died of his wounds at a base hospital. The destroyer escort USS Ringness (DE-590) was later named in his honor. To date, USS Ringness was one of only 19 ships to be named in honor of a Navy physician.

Surprisingly, more physicians received the Navy Cross in World War I (38) than in World War II (29). Among those heroes of the Great War are LCDR Lester L. Pratt and LT Malcolm L. Pratt. The Pratts hold the unique distinction as the only physician-brothers awarded the Navy Cross for the same engagement. The brothers Pratt would go on to serve in World War II. Malcolm Pratt and his son, Lt. John Lester Pratt, USMC were killed in the Guadalcanal Campaign. The father and son were later honored as namesakes for the destroyer escort USS Pratt (DE-363). Lester Pratt went on to oversee the construction of Naval Hospital Jacksonville and serve as its first Commanding Officer (1941).

Among the recipients of the Navy Cross there has been only one physician who received the award multiple times. LT John Brooks O'Neill was awarded the Navy Cross in 1927 and again in 1928 for efforts in the Second Nicaraguan Campaign.

The Navy Cross was last awarded to a Navy physician in the Vietnam War. The most recent Medical Corps Navy Cross recipients are four surgeons—CAPT Harry Dinsmore, LCDR David Lewis, LCDR David Taft, and LT James Back—all awarded the Navy Cross for removing live ordnance from the bodies of wounded personnel.

Sources:
Award Citation Collection. BUMED Archive.
Thompson, James. Complete Guide to United States Navy Medals, Badges and Insignia, World War II to Present. Fountain Inn, SC: MOA Press, 2003.

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coordinated offensive but too often the outcome from a routine patrol. On a near nightly basis, the Southern Region Commanding General (3rd Infantry Division at the time) came off the battlefield wearing his flak and Kevlar covered in dust and dirt from the day to conduct Purple Heart ceremonies while the recipients were still in theater. These were mostly Soldiers, but just like the Sailors and Marines we saw, they were whisked out of country in a highly effective evacuation system. After a particularly difficult ceremony I asked him what gave his soldiers the courage to put on their gear day after day knowing these catastrophic injuries could happen to them at any time? His response was quick, without any hesitation, "You guys Doc, they know if they make here, they have a 99% chance of surviving. It makes them feel like Superman."

As physicians we will need to be comfortable in both the medical center and the operational world. We should not devote our careers to one or the other, but believe they are the same.

Our job in 2019 and beyond is to maintain and build the warfighter's confidence that "we've got this." New solutions that will be employed across the oceans are in all stages of development. They must cut through the red tape and match the exponential growth of new technologies while outpacing our "near-peers." Time is critical but the answers must also be sustainable in the long term. We are entering an age of innovation and solutions will become evident that are hard for the most forward thinkers to imagine.

As physicians we will need to be comfortable in both the medical center and the operational world. We should not devote our careers to one or the other, but believe they are the same. We will function best by eliminating any barriers between them. Principles of high reliability organizations and standards of good medical practices that we all accept in brick and mortar facilities should be applied in the operational setting with vigor when feasible. Medical teams will be more disbursed, smaller and often without communications. For procedure oriented physicians they may face long periods of low volumes until a high volume or high acuity event occurs and then they must be really ready. World events demand we focus on the operational environment as much of our large organization focuses less on the MTF.

As usual much will be expected of physicians. For us it is not a binary problem. We must always keep the patient at the center of our focus wherever we find that patient and no matter what mission we're on. We must achieve expertise with expeditionary equipment AND at the console of a DaVinci robot. Our line leaders are increasingly aware of this challenge. They are increasingly concerned with the details of expeditionary care and still want state of the art, cutting edge care at home. At the end of the day, they will inevitably ask us the question, "You've got this, right Doc?"

We owe them and our patients a yes.

USAFP Recognizes 2 Navy Physician Leaders! Congratulations...

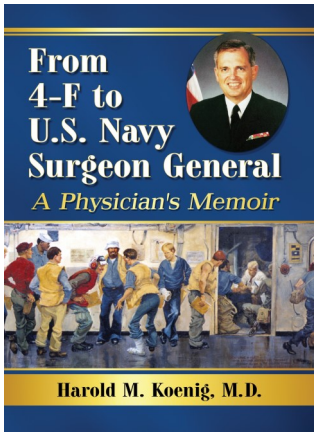
Two Navy Physicians were recognized at the 2019 Uniformed Services Academy of Family Physicians annual meeting this spring:

CDR Robert Laird
Family Medicine Physician of the year
CDR Adolfo Granados
Family Medicine Operational Physician of the year

Both selections were made from a highly capable group of Triservice physicians. Dr. Granados' career shows an exceptional dedication to the operational community. This most recent recognition was for his work as the Group Surgeon for the 3rd Marine Logistics Group, III Marine Expeditionary Force (III MEF) in Okinawa Japan. In that role he created substantial gains in the Marine Corps Medical Home, collaborated to develop a Combat Stress Platoon as a new mental health capability for the 3rd MLG and deployed in support of Khan Quest strengthening the U.S. and Mongolian Partnership.

CDR Laird won the Michael J Scotti Family Medicine Physician of the year award. He was recognized for his dedication to pain management and education, as well as his joy for practicing broad spectrum Family Medicine. He has taught many clinically validated auricular acupuncture protocols in locations such as Naval Medical Center Camp Lejeune, the Intrepid Spirit Concussion Recovery Center, Naval Medical Center Portsmouth, University of North Caroline at Chapel Hill, and Uniformed Services University of Health Sciences seeking to reinforce options for non-pharmacologic and non-opioid treatment options. CDR Laird also sought to spread his joy of practice through a "Joy" focus project, improving the quality of the work environment at the NMCCL Family Medicine clinic, which created a positive impact on providers and support staff. CDR Laird presented these positive findings at the national conference Society of Teachers of Family Medicine, so that other locations could benefit as well. He has since completed a Fellowship in Obstetrics, making him a considerable asset with a broad skillset, and a great example of what Family Medicine can bring to Navy Medicine.

VADM (ret.) Koenig's memoir now available



In 1959, Harold M. Koenig was discharged after his first year at the U.S. Naval Academy because of progressive hearing loss and went on to college, then medical school. In 1965, the draft board notified him that upon completion of his internship in 1967 he would be drafted despite his disability– as the conflict in Vietnam escalated, many doctors with previously disqualifying medical conditions were reclassified as eligible to serve. Rather than wait to be drafted, Koenig volunteered for a Navy program that made him an ensign and paid all expenses for his final year of medical school. His memoir recounts his remarkable career path from 4-F midshipman to vice admiral and his service in the most senior positions in military medicine.

VADM Harold M. Koenig recently published his autobiographical memoir, From 4-F to U.S. Navy Surgeon General. This is the first time in 60 years that a Navy Surgeon General has published a memoir, the last being RADM H. Lamont Pugh's Navy Surgeon (Philadelphia, PA: Lippincott, 1959). A list of several other autobiographies, biographies, diaries and memoirs written by Navy Medical Personnel is published on the Medical Corps Chief Webpage.

Update from the Reserves continued…

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tient outcomes in their civilian practice is a valuable resource to military healthcare. The emergency room physician in a busy civilian hospital or the trauma surgeon who practice is a major level I trauma center have experiences on a daily basis to maintain currency in critical skills and abilities needed when called for an operational mission or to augment a MTF.

Evidence also supports that bringing in different perspectives to an enterprise improves outcomes at many levels. Some reserve medical officers have unique skills and expertise in areas that are needed for training programs to maintain ACGME accreditation. In some locations areas this may not be found at military medical center or military treatment facilities. Reserve medical officers help by augmenting graduate medical education programs. Another example of a unique contribution is how Navy Medicine and the Defense Health Agency are using the expertise of some reserve physicians with extensive experience as chief medical officers and consultants for civilian healthcare systems. One project has a physician working on the evaluation of high cost / high utilization at large military medical centers. The healthcare professional in the reserves will likely be a key advisor to Navy Medicine and the Defense Health Agency as additional partnerships are explored in the future.

Surgical team from Expeditionary Medical Unit -5 in 2018 (Photo courtesy of CAPT John Lane).

On the operational front, Navy Medicine is moving toward unit mobilizations with an emphasis on tiered readiness for Expeditionary Medical Facility (EMF) and Forward Deployed Preventive Medicine Units (FDPMU). However, we still have quite a few IA requirements as over 45 reserve medical officers will be mobilized as IAs in FY 2020. This creates challenges as this requires some of the same specialties that are needed to maintain readiness for potential mobilizations for reserve EMFs and other operational communities (Marine Corps, aviation, fleet, special warfare, etc) More analysis in the works to evaluate reserve capacity for various types of mobilizations while maintaining readiness for these requirements.

As Navy Medicine transforms in the future, use of the reserve component will be necessary in order to continue to succeed in the future. Even during this dynamic time of change with some uncertainties about future structure and organization, there will always be a need to have trained and experienced physicians available and ready to provide support to our Navy and Marine Corps warfighters.

Expeditionary Medical Unit -5 assigned to US Central Command 2018 (Photo courtesy of CAPT John Lane)

Naval Health Clinic Annapolis Surgeon Participates in US-Asia Traveling Fellowship

CDR Lance LeClere, stationed at Naval Health Clinic Annapolis, recently participated in a month-long scientific exchange in Asia. Sponsored by the American Orthopaedic Society for Sports Medicine (AOSSM), in partnership with the Asia Pacific Knee and Sports Medicine Society (APKASS), the traveling fellowship included stops in Japan, Korea, Taiwan, Hong Kong, and China.

During the traveling fellowship, CDR LeClere was immersed in a scientific and cultural exchange. Each stop included tours of important cultural landmarks, visits to the operating room and sports performance centers, and was capped with didactic sessions. CDR LeClere delivered talks on suprascapular nerve compression and posterior shoulder instability, discussing published research papers and sharing lessons learned from a military population.

CDR LeClere observed fusion of eastern and western medicine, rigorous scientific study, and excellent surgeries including meniscal transplants, shoulder stabilization and rotator cuff repairs—and even ACL and PCL reconstructions using synthetic ligaments while in China! He also had the opportunity to visit sports performance centers in Seoul, Shanghai, and Chengdu, as well as Olympic training centers in Hong Kong and Taiwan. The tour was capped off in Chengdu, China at the APKASS Summit, where CDR LeClere and his 3 American colleagues were guests of honor and delivered keynote addresses.

The experience was a lifechanging experience for CDR LeClere. The knowledge gained, techniques observed, and relationships formed will leave a lasting impression on his practice--to the benefit of military patients and their families!

CDR LeClere shares his experience and discusses the nuances of shoulder instability in a young, active military population.

Medical Corps Career Development Board Program Roll-Out

As you are hopefully aware, the Medical Corps (MC) Career Development Board (CDB) policy was recently signed and the roll out of the program has begun. CDR Joel Schofer has been selected as the MC CDB Program Manager and CAPT Marlene Sanchez has been selected as the MC CDB Assistant Program Manager – thanks very much to both of them for serving in these critical roles! Thanks also to the many dedicated MC members who have been performing CDBs at their command and contributed to inform the development of resources as we move forward.

In order to maximize the professional development of all MC Officers, this policy applies to all active duty MC members, no matter where they serve. The policy as well as CDB resources are available (along with loads of other very useful information!) on the MC Home Page: https://esportal.med.navy.mil/bumed/m00/m00c/M00C1/ (CAC required, use email certificate).

You will be hearing more from CDR Schofer in the near future.

How to capitalize on 'Free Leave' and Help the Mission...

Did you know that MTF and NMRTC CO's have been specifically encouraged to authorize Permissive TAD for Medical Corps officers travelling in order to assist local recruiters with medical students? This program is subject to local policy, however is a great opportunity, especially for junior medical corps officers, to foster career-enhancing relationships with pre-medical and medical school organizations. Please note that it is unlikely that a recruiting district can pay for your travel, but the Permissive TAD incentive is there in case you were planning on personal travel to visit friends, family, or your alma-mater anyhow.

There is unfortunately no Medical Corps Officer presence at Navy Recruiting Command. As such, the Medical Corps must take a proactive approach to help determine our future leaders. This can be done by (1) Conducting Officer Candidate Interviews (must be LCDR or above) or (2) speaking to individuals or groups of potential HPSP candidates. Both can be facilitated through MedicalVIP.fct@Navy.mil, a dedicated inbox for applicants and Medical Corps Officers interested in assisting Navy Recruiting Command.

How you are able to help is up to you. As most of us were once curious pre-medical students, we remember most people are just looking for an honest conversation with someone who has been through it themselves.

As always, if you have any difficulty utilizing this initiative (referred to as 'Hometown Heroes'), please email any contact in the Corps Chief's Office or the Medical Program Manager at Navy Recruiting Command, LT Shannon Evans (Shannon.Evans1@Navy.mil).

Who Ya Gonna Call?

In honor of the 35th anniversary of the release of the original Ghostbusters (June 8, 1984), which I still can remember seeing at the post theater at Yongsan, Korea, it seems wholly appropriate to take the title of this article from its earworm of a theme song.

One of the highlights of my job in the Corps Chief's office is getting to interact with you in formal and informal settings, and these interactions are a never-ending source of great questions. During a panel discussion at the MHS Female Physician Leadership Course in April, I was asked about the division of labor between detailers, specialty leaders and the Corps Chief's office. There definitely is overlap in our responsibilities, so I thought this would be a great topic to cover in the newsletter.

Detailers are most famous (or infamous depending on your experience) for issuing orders of all varieties, and they work closely with the specialty leaders to make sure they factor in larger specialty and career development issues. Less well known to most people are the community managers and placement officers who work on behalf of the commands and the Medical Corps as a whole to balance the needs of the individual with the needs of the Navy. Additionally, detailers should be your go-to for things like maintaining or correcting your service record, adding additional qualification designators, and anything involving the Military Personnel Manual (MILPERSMAN).

Specialty leaders are appointed by the Surgeon General (SG) and serve as his principal advisor for their clinical specialty. In this capacity, they provide subject matter expertise regarding standard of practice in both the military and private sector healthcare systems and inform policy development both internally and externally (e.g. partners such as the Defense Health Agency) – and all of this is on top of their full time jobs! The SG and Corps Chief also rely on them to serve as conduits for information, provide mentorship for clinical and professional development, and provide counsel to detailers and the Regional Plans, Operations, and Medical Intelligence (POMI) shops (amongst others) regarding assignments and deployments.

The Corps Chief's office supports the Chief of the Medical Corps and the Medical Corps as a whole; we are advocates for all specialties, and we rely heavily on the specialty leaders to alert us to issues they are seeing at the deckplate level. We work plans and policy issues that impact the Corps as a whole, coordinating with the detailers, Regions, other BUMED "M codes" and various external agencies as necessary. On a more individually relevant level, the whole Corps Chiefs office, to include our sister Corps, and senior detailers work together closely for both the milestone and command screening and selection processes. We also manage quotas for a subset of senior leadership development courses (e.g. AMDOC) and are in the midst of establishing a formal Career Development Board program to ensure that all of you have routine access to timely and useful career advice. We also play key roles in Navy Medical Department accessions and Graduate Medical Education (GME), working closely with the Navy Medicine Professional Development Center and, more recently, the Defense Health Agency, to support Navy GME and help develop the future of the Medical Corps.

While we all have our wheelhouses, detailers, specialty leaders and the Corps Chief's office work together to advocate for the Medical Corps. Hopefully this discussion has helped to clarify our respective roles, but ultimately, it does not matter who you call. The important thing is that you call. We are all here to help you, so even if we cannot give you an answer or solve your problem ourselves, we can get you to the person who can.

PERS Pearl….

SELECTION BOARD NOMINATIONS:

Would you like to be considered to serve as a member or a recorder on a selection board? Each year we need approximately 30 Medical Corps officers to serve on selection boards for promotion. The composition of each board is carefully constructed to ensure an adequate number of members have prior board experience and that each board is representative of our Corps in terms of gender, ethnicity, medical/surgical specialty, regional location, and operational/MTF assignment. There are, of course, also rank requirements for each board, as we cannot have a board full of LCDRs choosing our next CAPTs! (as interesting as that might be!)

PERS will be accepting nominations for board members and recorders until 30 Sep each year for the following board season. You may self-nominate, or ask your specialty leader or your command leadership to nominate you. Please contact your specialty leader or your detailer for the nomination form. Once we have collected all nominations, we will construct the boards in keeping with all requirements, and contact those selected to determine availability.

Participating on a promotion selection board is an excellent opportunity to help shape the future of our Corps. But, with the limited number of available seats and the requirements needed for each board, finding available candidates can sometimes be challenging! So, please do not give up if you are not selected to serve on a board this year. Keep applying in future years! Your persistence and patience is appreciated! Thank you for considering and we look forward to receiving your nomination.

Accessing the Corps Chief Homepage (if unable to hyperlink directly)

- Go to www.med.navy.mil
- Click on 'Internal Site (CAC Enabled)' located on the top banner, far right (next to facebook, twitter icons)
- Select either hyperlink option to access BUMED Sharepoint (the second option for 'non-navy medicine' is more reliable if outside the DHHQ network). Use your CAC EMAIL certificate for access.
- Click the 'Surgeon General' dropdown menu located on the top banner and select 'M00C– Corps Chiefs'
- Click on 'Corps Sites' dropdown menu located on the top banner and select 'Medical Corps (M00C1)'
- Bookmark this site and please visit regularly for updates!

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: **$10/coin**

+ postage

(varies by weight & zip code)

Please email **CAPT William Beckman <william.a.beckman.mil@mail.mil>** with the following information:

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

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

For further assistance, please feel free to contact us directly...

Corps Chief's Office

Deputy Corps Chief
CAPT Chris Quarles, MC, USN
Christopher.s.quarles.mil@mail.mil
(703) 681-8917; DSN 761-8917

Career Planner
CAPT William Beckman, MC, USN
William.a.beckman.mil@mail.mil
(703) 681-8937; DSN 761-8937

Reserve Affairs Officer
CAPT Jay Shirley, DC, USN
Jc.shirley.mil@mail.mil
(703) 681-8938; DSN 761-8938

Plans and Policy Officer
CDR Melissa Austin, MC, USN
Melissa.c.austin6.mil@mail.mil
(703) 681-9128; DSN 761-9128

MC Liaison Officer
LCDR Brett Chamberlin, MC, USN
Brett.m.chamberlin.mil@mail.mil
(703) 681-6622; DSN 761-6622

Navy Medical Corps Detailers

Surgical and Executive Medicine
CDR Todd Gardner, MC, USN
Todd.a.gardner2@navy.mil
SURGICAL_SENIOR.FCT@NAVY.MIL
(901) 874-4094; DSN 882-4094

Non-Surgical Medical Specialties
CDR Alicea Mingo
Alicea.m.mingo@navy.mil
NON_SURGICAL.FCT@NAVY.MIL
(901) 874-4046; DSN 882-4046

Family and Operational Medicine
CDR Anja Dabelic
Anja.dabelic@navy.mil
FM_OPERATIONAL.FCT@NAVY.MIL
(901) 874-4037; DSN 882-4037

GMO and GME Detailer
LCDR Jennifer McNab, MSC, USN
Jennifer.mcnab@navy.mil
GME_GMO.FCT@NAVY.MIL
(901) 874-4045; DSN 882-4045