Spring 2021

THE MEDICAL CORPS NEWSLETTER

INSIDE THIS ISSUE:

-From the Corps Chief

-Leadership with CAPT Sears

-Tips for the GMO

MEDICAL CORPS
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MEDICAL CORPS NEWSLETTER

INSIDE THIS ISSUE:

From the Corps Chief—3

Chief Medical Officers—5

Photograph of the Quarter—7

Spotlight: CAPT Sears—8

Virtual Mental Health Pilot—13

Tips for the GMO—15

The Leatherneck Physician, Part 2—17

Future Physician—19

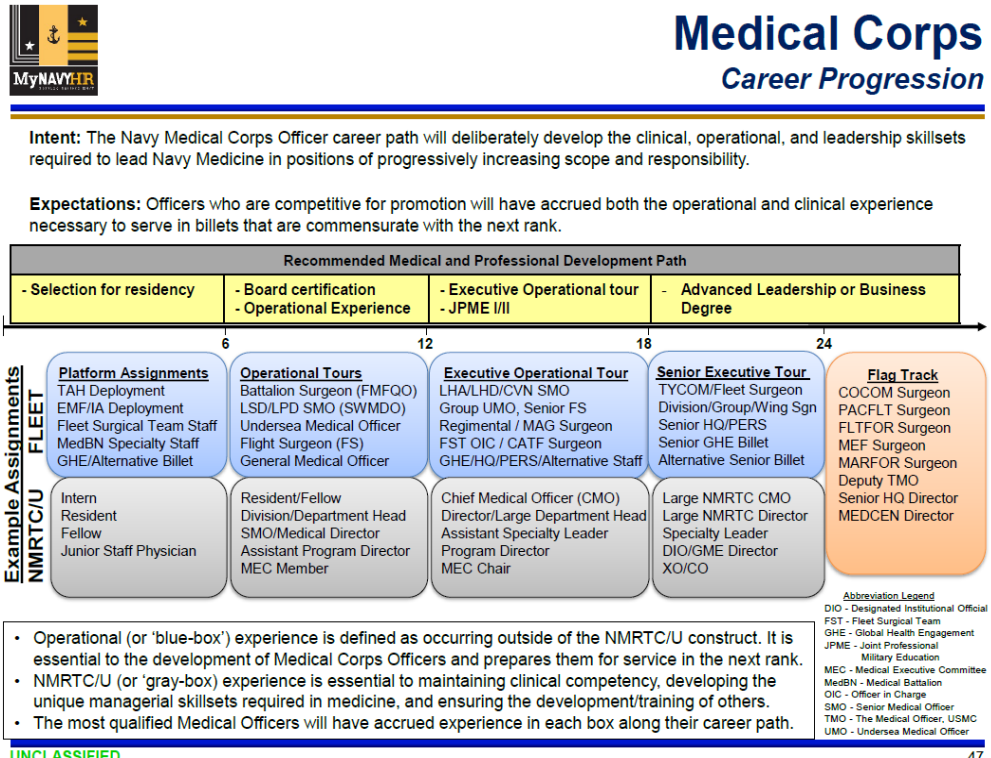
Key Contacts—19

FROM THE CORPS CHIEF...

Shipmates,

I wanted start off this newsletter by congratulating the Corps on a historic 150 years of service. When the Appropriations Act of March 3rd 1871 was signed, few would have guessed that 150 years later we would have over 4200 Active Duty and Reserve Medical Corps Officers in all areas of the world assisting with a global pandemic that has taken the lives of over 2.7 million people. The 153 physicians in the Navy in 1871 would be just as proud as I am of each and every one of you. Whether caring for patients in austere conditions or setting up vaccination centers within the U.S., your dedication and service is commendable and should be celebrated. Take a minute today and appreciate all that you do for this nation.

Next, I want to discuss some new information from the FY22 promotion boards, something that is relevant regardless of whether you plan to make the Navy your career or not. The recently published selection board precept included a page emphasizing the new policy barring the board from considering any history of "opting out" of promotion boards or utilizing the Career Intermission Program. Utilizing the Career Intermission Program to take time off for your family or pursue your education can NOT be counted against you when you are competing for promotion. MyNavyHR also published the new Merit Reorder Considerations and Career Progression guidance that are being provided to the FY22 promotion boards. While these are excellent



guidelines to know what the boards are looking for when it comes to your career progression, strict adherence to them is not a prerequisite for promotion.

When advising officers on promotion, I always start with the current year's precept. The FY22 O6 convening order has been released with important takeaways. The new maximum promotion opportunity for all boards is 95%. This came from the 2021 NDAA and means we will no longer have a 100% opportunity for O4. Basically, not everyone gets a trophy. Hopefully this will drive officers to seek career development boards earlier in their career and improve the mentorship provided. The promotion opportunity for O6 changed from 91% to 90%. There is now a greater emphasis on knowledge of Great Power Competition (GPC) and the INDOPACOM AOR, professional education like JPME, continual performance improvement, operational employment, character, and diversity. This is consistent with the focus shift to the INDOPACOM AOR and our peer/near peer adversaries as well as recent emphasis on JPME and operational specialties. There is also a paragraph about not disadvantaging anyone whose fitrep was adversely impacted by COVID.

Each and every one of you is important and every specialty is vital to the functioning of Navy Medicine and the Navy as a whole. In order for the warfighter to do their job, we need to do ours. I think it's important that each and everyone one of you understand that while we are NOT "trigger pullers", we are VITAL to the warfighting effort. Thank you again for what you do each and every day and once again, don't hesitate to reach out to me or my staff if there is anything we can do to support you.

Medical Corps
Community Values

- **People**
  - Achieve and maintain board certification
  - Maintain current clinical competency and active clinical practice in their specialty
  - Education outside GME (JPME I/I, MHA, MPH, MBA, etc) valued
- **Platforms**
  - Operational experience is required to provide subject matter expertise for senior line leaders
  - Contributions in the operational or deployed setting are expected throughout a career
- **Performance**
  - Officers are expected to have diverse careers that balance clinical skills sustainment and operational experience, using experience gained by this diversity to improve the support provided to our warfighters
  - Expected to assume increased leadership responsibility as they progress
- **Power**
  - Navy or DoD-wide impact that allows Navy Medicine to project medical power is highly valued

FY-22 Active Duty Staff Merit Reorder Considerations Brief Disclaimer

This community brief has been generated by the community leaders, including detailers and community managers. It has been vetted by Navy Personnel Command and OJAG for statutory compliance and approved by SECNAV.

Community leaders have provided these slides to community members for career planning purposes; however, strict adherence to the career progressions depicted in the slides is not a prerequisite for promotion.

ONLY MATERIAL APPROVED BY THE SECRETARY OF THE NAVY WILL BE PRESENTED TO STATUTORY SELECTION BOARDS. THIS BRIEF HAS BEEN APPROVED BY SECNAV FOR USE BY THE FY-22 STATUTORY SELECTION BOARDS.

Chief Medical Officers: A Platform for Advocacy for the Medical Corps

By CDR Brett Chamberlin
Chief Medical Officer, USNMRTC Guam
Assistant Specialty Leader, Internal Medicine

As orders are being cut and the familiar drumbeat of the PCS season approaches, many of us are considering the next step in our career. DHA has assumed increased authority over healthcare delivery and business operations, while Navy Medicine continues its operational pivot projecting medical power in support of the Fleet. The success of both missions depends on Navy Doctors, so how do we take care of our people?

1. Force Management. The Medical Corps has traditionally been managed via our Specialty Leaders. They are responsible for the leadership of their communities across several different MTFs. Since the Chief Medical Officer (CMO) position was implemented, each MTF has had a designated senior leader responsible for leading the Medical Corps across several different specialties. This creates an (X,Y) grid management system that allows the Corps Chief's Office to coordinate with Specialty Leaders and CMOs. This process enhances communication and force management while providing a starting point for problems that require enterprise-wide solutions.

2. Strategic Leadership and Physician Advocacy. CO's and XO's are by definition 2XXX (meaning any Corps can fill the position) and have equal responsibilities to everyone in their Command. Similarly, Directors and the MEC Chair are primarily charged with the MTF mission and responsible for all-corps leadership. By centrally screening and slating Chief Medical Officers, the Corps Chief's Office is able to ensure that a focus on the strategic leadership, advocacy, and development Medical Corps Officers will always be central to MTF leadership. This is the same model employed by the Nurse and Medical Service Corps regarding their Milestone-equivalent leadership billets (SNE and DFA, respectively).

3. Partnerships and MHS Integration. The CMO is in effect a dual-hatted responsibility. In addition to the above extension of the Medical Corps Chief's Office, they also serve as an extension of BUMED M5 (Office of

the Chief Medical Officer). By leading the efforts of our High Reliability journey, CMO's are able to engage with leaders across the MHS to share best practices, facilitate communication, and improve the processes that often frustrate us all. The CMO network is an effective platform that allows leaders to work across MTFs and help drive positive change.

I realize that I don't know over 3500 of you who may be reading this, but wanted to lend my thoughts on a career opportunity that some may find very rewarding. If done well, Physicians who choose to become CMOs can be an effective force to improve the lives of their fellow physicians.

Happy Doctors = Good Doctors = Good Medicine. Which is exactly the mission we serve.

Anyone interested in understanding more about screening for Chief Medical Officer should reach out to their local CMO or feel free to email me at brett.m.chamberlin.mil@mail.mil.

LT Hannah Geverd, an internal medicine physician at Naval Hospital Jacksonville. (U.S. Navy photo by Deidre Smith, Naval Hospital Jacksonville/Released)

PHOTO OF THE QUARTER:

THE COVID-19 VACCINE

Lt. Cmdr. Kelly Peng, an emergency medicine physician assigned to U.S. Naval Hospital (USNH) Naples, is all smiles after completing the Moderna coronavirus (COVID-19) vaccine observation period onboard Naval Support Activity (NSA) Naples, Jan. 8, 2021. USNH Naples, the largest naval hospital in Europe, serves a diverse population of over 9,800 beneficiaries. Over 500 staff members at the main hospital, branch health clinic, and Navy Liaison Detachment in Landstuhl, Germany work tirelessly to keep warfighters in the fight and provide care for their families. (U.S. Navy photo illustration by Mass Communication Specialist Erika L. Kugler)

Leadership in Practice:

CAPT Chris Sears

Born at Norfolk Naval Hospital, Captain Sears (née Gray) graduated with a Bachelors of Arts in Engineering from the Johns Hopkins University in 1989. She earned her Medical Doctorate at Northwestern University Medical School in 1993 and completed a surgical internship at Naval Medical San Diego (NMCSD). She then served as a GMO on board USS MCKEE (AS-41), and returned to NMCSD for urology residency. She completed Fellowship in Female Pelvic Medicine and Reconstructive Surgery at Walter Reed Army Medical Center. Dr. Sears then served as XO, Naval Hospital Jacksonville, and as USNAVSO/USFOURTHFLEET Surgeon. During her tour as USNAVSO/ USFOURTHFLEET surgeon she also served as commanding officer of the Medical Treatment Facility on board the USNS COMFORT (T-AH 20) during Continuing Promise 2015. She then served as Commanding Officer, Naval Health Clinic Oak Harbor, during a large renovation and the roll out of MHS GENESIS. She now serves as the US SEVENTHFLEET Surgeon, overseeing Navy medical care and policy and health engagement for the Western Pacific and Indian Oceans. She has been selected as the next US Southern Command Surgeon.

When I received the offer to contribute to this issue of the Medical Corps Newsletter, it was several days after the Memorial service for my brother, LCDR (s) Jeffrey Gray, an internist at Walter Reed National Military Medical Center. As I began to write, former President Donald Trump was being admitted to WRNMMC for COVID-19. As I completed the 1st round of edits, he had returned to the White House, and former Governor Chris Christie had recovered from COVID-19 after 7 days in the ICU and was encouraging mask usage. As I complete final edits, President Biden is placing control of the pandemic front and center in his priorities and many of us are being mobilized for mass vaccination stations around the country. By the time you read this, other significant events in which healthcare is front and center of our national and international discourse will have occurred.

As military physicians we are better prepared than many to survive and thrive in the current environment. Although we serve our individual patients as our civilian colleagues do, we also have an even greater responsibility to national security. The medical care of senior national leaders are perhaps the most obvious example of this dual responsibility to patient and nation, but this dual responsibility is always before us. It is made even more obvious in times of crisis as we have seen this year. We have worked out of our primary specialty, out of our comfort zone- in order to promote national security and defend international norms amidst the threat of increasing international competition and a global pandemic. Like many of us in the Medical Corps, I originally joined the Navy to pay for medical school. I came from a Navy family - both grandfathers,

my father, and my uncle had served. My mother had worked at the Naval Research Lab, and I was literally born into the Navy at Norfolk Naval Hospital. I started medical school wanting to become an OB-GYN to combat maternal and child mortality in low income countries. However, I fell in love with surgery late in my third year, and was grateful to have a separate internship during which to decide what type of surgeon to become. My surgical internship gave me time to know urology as my niche. I owe the late CAPT John P. Sands much appreciation for all his encouragement and support; his gruff style of mentorship suited me well.

Like most Navy physicians in those days, I had a General Medical Officer tour in between internship and residency. As the shipboard options for women were limited, I was stationed on the submarine tender USS MCKEE (AS-41). Although we did not go to sea often, it was a test of our independence as physicians when we did. There are many sea stories, but the one with the broadest application to all of us is the following: A Sailor on MCKEE had CNS sarcoidosis resulting in panhypopituitarism and normal pressure hydrocephalus. The medical record indicated that the associated central diabetes insipidus was so severe that the Sailor would likely die from dehydration within 48 hours of a missed dose of DDAVP. When I reached back to the specialist because of a concern for fitness for shipboard duty, I was rebuffed. When I expressed my concern if his intracranial pressure were to increase, my only recourse at sea was intubation and manual hyperventilation, I was reminded that as a recent surgical intern, that was within my scope of practice. My medical recommendation to command leadership was to leave the sailor behind on the shore detachment to avoid that risk at sea. This story demonstrates the tension between the dual nature of our practice- the specialist at the Medical Center saw the patient's health as a medical success from the recent development of intranasal DDVAP. While I agreed with that assessment, I also saw the sailor had a persistent elevated risk for death or disability at sea, and saw his illness as a liability for the ship to remain on

CAPT Chris Sears
US SEVENTHFLEET Surgeon

mission.

On September 11, 2001, I was checking into Naval Hospital Bremerton (NHB) as a new staff urologist. When my husband Steve called me from work around 0630 PDT, I, along with many Americans, was stunned. The events of that day molded me; my commitment to the Navy and our nation became more focused and I began to prepare mentally for the inevitable conflict. Since then, our country has been at war in Iraq, Afghanistan, and in many other parts of the Middle East. As a urologist, I have had the honor of assisting in the recovery and rehabilitation of many who served in these conflicts- from soldiers with urolithiasis from Iraq to Marines with severe pelvic injuries from IED blasts in Afghanistan. I have also been blessed to help care for underserved families in Central and South America and the Caribbean, including

pelvic reconstructive surgery on USNS COMFORT for some incredible women (as close to my initial reason for going to medical school as possible!). The dual nature of our practice has been ever present- caring for the patient in front of us as a part of caring for our nation.

The most recent need for this duality in military medicine is the current pandemic. I currently serve as the 7th Fleet Surgeon, embarked on the USS BLUE RIDGE stationed in Yokosuka, Japan. When it became clear the pandemic would affect our operations, we began to plan for options to defend against its effect and for what we would do if and when it breached our defenses. The medical department worked hand in hand with our security team and ultimately the whole staff to lay out potential courses of action. Early on there was not much published data to assist us, and the data that did exist was very concerning for widespread transmission on ships and significant hospitalization, ventilation, and death rates. The dual nature of our practice was front and center- clearly we had to protect and if necessary test and treat the patients, but more importantly, we had to work hard to keep as many ships at sea as possible to meet mission. Like most physicians, my work is (almost) my life. It intertwines with my personal life in ways that are hard to imagine in medical school. All physicians experience some of this - the sleepless nights in training, the call from the hospital that interrupts Thanksgiving dinner, the many times a child's sporting event is missed. For us in military medicine this can be even more challenging - months and sometimes years of separation from family, stressors from combat, challenges of practicing in an environment where we can't order every indicated study – these are all part of our daily lives as military physicians. Working thru these very challenges can help prepare us for the current times. How do we ensure we thrive in this environment?

I believe the first step is to have and express gratitude. We all have so much for which to be thankful. As we've seen this year during the pandemic, much of our social fabric can be weakened quickly. We have a common purpose; we have meaningful work to do; and we are paid for it. Most of us are insulated against the current financial challenges and food and housing insecurity many are facing. Whether you have worked in your chosen specialty this year, or have flexed towards more internal medicine or public health, you are part of the elite group of Americans who is steadfast and continues to do the hard work of maintaining the ideals set forth in the Constitution. The past year has returned many to the bottom 2 levels of Maslow's hierarchy. We retain access to food and shelter and clothing. As physicians we sometimes put our health at risk for that of others- when we have PPE and sleep, we should be grateful for these as well. Sometimes even "faking it" can work- it may seem silly to be thankful for the hot running water in your shower, but you are one of the very few people in history to have that luxury. Practicing gratitude even in little ways gradually shifts your mind and you begin to see so many more things that bring you joy.

The second is patience. In medical school I once stood on a table and shouted expletives at the front desk of a radiology department who had lost three sets of preoperative films. Once the fourth set was done, I hid them under the mattress of the call room so I could pull them out on rounds to show the surgery chief resident. Although I was certainly "in the right" in defending my patient against the threat of unnecessary radiation and bureaucratic delays, it was not the right way to manage myself or the situation. So if patience is not inherent in you (as it wasn't in me) – I have some suggestions. First, gain some perspective - go for a walk, go for a run, meditate, do yoga, go fly fishing- whatever decreases your stress reaction. Then re-approach the problem. It always is better after a pause. Even if it's really an emergency, you can usually take a deep breath- in and out, to reset your mind. In other words, take your own pulse, and then slow it.

The third is flexibility. Other than my orders to internship, residency, Bremerton right out of residency, and my in-the-works orders as SOUTHCOM surgeon, not one of the remaining sets of orders I have received in 27 years of Naval Service has been my first choice. Only once were they my second choice. Three times they existed only because something happened suddenly in another officer's life that rendered an opening into which the Navy placed me. Over the years, I have slowly learned that doing what I want is not always the best opportunity for growth. As our colleague CDR Jason Blitz's email tagline says, "Sometimes you don't

get what you want. You get something better." What can we do individually to help with our own internal mental flexibility? My recommendation is to intentionally seek out mildly uncomfortable situations- whether it is forgoing the hot water in the shower from time to time, trying a new food, travel, or form of exercise, the more we accept and seek out small changes, the easier the next change is. Additionally, staying physically fit helps. I also recommend a portable hobby, preferably not electronic. Whether it's reading a book, tying flies, doing Sudoku or crossword puzzles, playing cards, anything that focuses you temporarily off your challenges can help tremendously. Physical fitness and small hobbies can provide comfort and continuity when life is disrupted by deployment or other change that seems overwhelming.

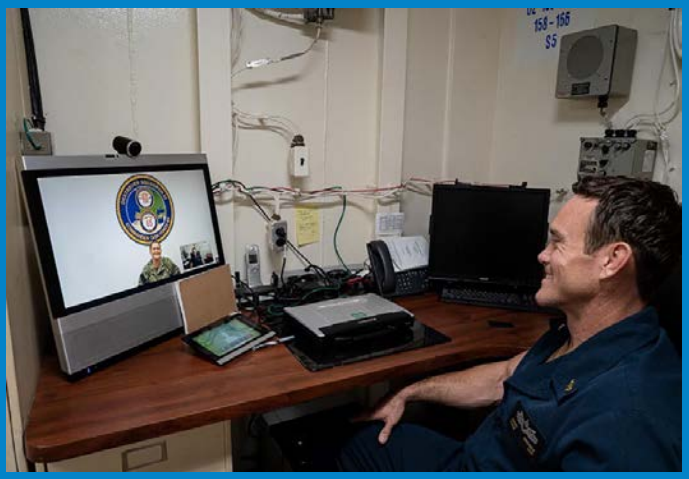
2020 was a very tough year. Many of us as worked the longest hours than we have since residency. Additionally, there was discord throughout American society and although there is hope for 2021, thus far these challenges have continued. More personally for me, my brother Jeff, an incredibly gifted WRNMMC internist who was on the front lines as a clinician caring for patients with COVID-19, died from suicide and left a hole in the heart of our family and Military Medicine. I wonder what it would be like were he now fully immunized working at NMCSD, married to the love of his life, as planned a year ago. Although many of us have been challenged professionally and hurt personally, we must all press on, because there will be continued challenges before us. We must find gratitude, patience, and flexibility to move forward and continue to serve our patients and our nation.

As we work in our current pandemic world, wanting to strike a balance in policy and personal behavior that promotes safety for those at higher risk from death and disability from COVID-19 without leading to more discord and mental health problems for those at lower risk from this disease, we are all in a position to influence change. Immunization, which was just a dream when I first authored this article, has become a reality for most of us and has allowed us personal security while we continue to fight this fight.

We are in this together. You are better equipped than most to meet these challenges. Don't give up the ship!

The Promising Virtual Mental Health Pilot

Submitted by David Paz, MD, CDR MC USN



As the military healthcare system adjusts course to align with the Department of Defense's focus on warfighter readiness, Navy Medicine, in concert with the Defense Health Agency, is working to ensure both a ready medical force and a medically ready force. To do so, Navy Medicine must find innovative ways to integrate with operational units to provide adequate support and keep sailors mission-ready at sea. One of these innovations is virtual mental health care.

Poor mental health can have disastrous consequences if not addressed urgently and effectively. Previously, however, the primary option to provide sailors at sea with acute mental health care was a costly and potentially hazardous emergency medical evacuation to the nearest ashore facility, an evolution that can result in the ship losing many on-station mission days. Using shipboard technology to treat patients virtually was merely conceptual. A secure video teleconference consultation for a sailor at sea (a "VT-Sea") with a shore-based medical specialist had been demonstrated only once, in 2018, as a proof-of-concept for non-emergent cases. The success of the VT-Sea consultation on board the Arleigh Burke–class guided-missile destroyer USS Chung-Hoon (DDG-93) was captured in "Treatment on the Waves: Exploring the Potential of Medical VT-Sea," published by Carrier Strike Group 3 on the Defense Visual Information Distribution Service. In this proof of concept led by Navy Medical Forces Pacific, CDR James Bailey, an orthopedic surgeon, used VT-Sea to examine a patient aboard USS Chung-Hoon while underway.

Then in 2019, the virtual health team at U.S. Naval Hospital Rota, Spain, used their knowledge of the 2018 Chung-Hoon proof-of-concept to collaborate with Navy destroyers homeported at Naval Station Rota and mental health professionals at Destroyer Squadron 60 in Rota, Spain, to explore expanding VT-Sea care for mental health patients at sea. This pilot focused on acute patients, broadening the virtual health aperture, with the goal of providing sailors adequate care while under way, thereby limiting the need for medical evacuation and enabling the ships to remain on station to accomplish their missions. Connectivity testing with the four destroyers homeported at Rota was conducted to ensure a reliable service that meets current standard of care. Subsequently services were offered to sailors who had expressed acute distress while at sea, with full support from the ships' independent duty corpsmen, commanding officers and the commodore of Destroyer Squadron 60.

Using VT-Sea, mental health specialists also were able to rapidly determine if a sailor required emergency evacuation. An initial cost analysis conducted by Naval Hospital Rota estimated a medical evacuation from sea costs as much as $175,000 and incurs on average 60

workdays lost, in addition to the operational impact to the mission of losing key personnel. In 2018, 12 sailors from Destroyer Squadron 60 required medical evacuation from sea for acute mental health concerns, costing an estimated $2.4 million and 720 manpower days lost.

The implications of the Naval Hospital Rota mental health VT-Sea pilot are potentially far-reaching. The system could reasonably be used for other medical issues to assist the decision-making process for medical evacuation. Extending virtual care delivery across the medical spectrum could further decrease mission disruption, saving money and preventing days off station, and allow Navy Medicine to more fully integrate into operations at sea. As the Navy continues to modernize, it is imperative that Navy Medicine make the best use of cutting-edge communications technology, acknowledging that medicine is just one of many competing priorities operational commanders must balance while at sea and in harm's way.

Since the *Proceedings* article was submitted in May 2020, additional gains with VT-Sea have occurred. From the initial launch in July 2019 to March 2021, 60 VT-Sea sessions have occurred, with 23 medical evacuations averted, a $4.8M cost avoidance, and 2700 duty days saved. Additional successes include not just a decrease in mission impact and averting medical evacuations but the importance of assessing the patient in their operational environment as well as the opportunity to teach the independent duty corpsmen techniques to further use for their patients while at sea. NMRTC Rota intends to work with the Destroyer Squadron 60 to attempt in-hospital non-secure service lines as well, again by using technology organic to our warships.

Overall, this medical power projection success represents the unified effort of a multidisciplinary team of nurses, corpsmen, social workers and physicians that includes LT Olivia Peduzzi, LCDR Rebecca Miranda, LCDR Justin Deskin, LCDR Chris Weiss, and CDR Andrew McDermott with support from CAPT Rees Lee, CAPT Timothy Quast, CAPT Jean Fisak and CAPT Andrew Archila.

MEDICAL CORPS 150th CHALLENGE COINS

For a limited time only, the 150th anniversary Navy Medical Corps Challenge Coins are available for purchase at **$13/coin**. Buy some for your friends for a discounted price, **$35 for 3 coins**, **$55 for 5 coins**, and **$100 for 10 coins**. Contact Career Planner for further details: Anthony.w.keller8.mil@mail.mil

Tips for the GMO

By LT Roxana Y. Godiwalla

Transitioning from hospital medicine to operational medicine is quite the unique experience. Most of us don't have a great deal of training as GMOs, flight surgeons, or undersea medical officers, let alone working directly with COs. But, similar to being an intern or resident, the on-the-job training brings on a set of challenges that mold us into being superb in our work. After working as a GMO with the Marine Corps, I'd like to share some of my experiences and insights.

1. Be an expert in your technical skills, and make them tactical.

If one takes on the attitude of adapting his/her physician technical skills to 'physician tactical skills,' you will earn trust in your CO, as well as your Marines and Sailors. While providing medical coverage for Cold Weather and Mountain Warfare training, I was being 'field tested.' The exercise presented an opportunity to demonstrate initiative, follow through, problem solving, and providing medical services above the Marines expectation. These are the same expectations we have as interns and residents – figuring out the medical record system, how to ensure orders are executed, adjusting to changes in workups, imaging studies, and lab results, learning how to present to attendings and communicate with consulting services, and proactively expecting patients' needs in their care. Learning how to practice your subject matter expert clinical skills in austere combat conditions is a must for every operational physician. The competence and delivery of medical services to your Marines is a test of your capability and capacity as a physician, and one that you must not fail.

2. Do what they do – "embrace the suck."

Having humility while knowing your position helps your Marines and Sailors trust you. With this trust, they will look out for you. For me, that meant doing what they do, without

complaint and without fail. I recall the Cold Weather and Mountain Warfare course we completed at Bridgeport, CA. We had a lengthy hike in order for our battalion complete training. Traipsing through snow at altitudes of 9,000ft coming from sea level is not what most would like to do on our day off. The Marines expected we would do the nine mile hike, set up an STP, take care of all Marines that fell out, and partake in all hikes and training as part of the battalion. My medical team and I endured the same hardship, providing care and coverage for their musculoskeletal injuries and altitude sickness. The Adjutant of the battalion remarked to me when we crossed mile six of nine, 'Hoorah Ma'am, you motivate me!' I carried a pack more than half my weight and rucked with my Marines without complaint. They looked to me for encouragement in addition to ensuring all preventive measures were taken to prevent cold weather injuries and snow photokeratitis. Our medical team and

battalion expertly managed three separate mass casualties of Marines falling out of training due to cold weather-related injuries and altitude sickness. We could have easily reasoned our way out of doing all the trainings with the Marines, but 'embracing the suck' of hiking in torrential weather, all uphill, with heavy packs, gave our battalion a sense of trust and confidence in us that we would always pull through for them.

3. Learn the administrative functions of your command and the 'right side' of your collar.

The administrative functions of your job are equally important as your clinical duties. For most new GMOs, this is a foreign endeavor, but one that can be overcome in the same way we had to learn AHLTA, CHCS, and Essentris, and which individuals must be consulted and scheduled for a procedure or a patient discharge. Navigation of the medical administration is equally important as ensuring your Marine or Sailor has the appropriate follow up consult. For the active duty, it is the way forward to get the care and disposition they need and deserve. Being the subject matter expert of light duty, limited duty and all related dispositions while working with your S1, is a must. Understanding this process will give you the knowledge to best make giving optimal guidance to your CO. Don't forget that you are a Naval Officer and that responsibility is brought to the forefront while being operational.

4. Take ownership of your Marines, they are your patients now.

Taking the time to orient to your new patient population helps the average physician better serve and connect with their patients. Specifically, learning of the patients' values, ways of life, personal struggles, and common health disparities/recurring medical visits is vitally important. This integration and appreciation of the military culture and traditions earns more trust from your patients and in turn, more respect for you and your position.

5. Stay academic, stay relevant.

Keeping up your credentials and obtaining/maintaining your medical license in a timely manner is your responsibility. Physicians are not able to see patients in a training or hospital setting if their ALS/BLS expires, and should not happen while you are a GMO. While in GMO land, it can be challenging to attend academics, shadow/work in your specialty field of choice, and do networking. If you go to a billet with upcoming deployments and exercises, you may hardly have the time and opportunity to do much else besides operational training. Up To Date has been a great resource while being operational, and always reaching out to specialty duty providers when you are not sure of how to best workup or refer cases. I was fortunate enough to start a research project during intern year, and had the opportunity to do multiple presentations at both military and national conferences. This research gave me a venue to stay involved with my specialty department, and do networking. Scholarly work can still be done during deployment. I brought a textbook while on deployment, and read about various pathologies and workups. If able, you can attend academics, or work with your base hospital to set up an occasional clinic or OR day. Case reports are another easy and interesting way to do something academic, even if the write up has nothing to do with the specialty you are applying for. As physicians we are expected to stay abreast of our specialty updates, and should take on the same attitude while we are doing our operational tours.

At the end of the day, if you just remember the oath you took while you were in medical school and the oath you took to become a Naval Officer, and honor your commitments, you will succeed and make the most of your time as a GMO.

1St Marine Logistics Group

U.S. Marine Corps photo by Sgt. James Treviño

THE LEATHERNECK PHYSICIANS:

Part II: Physicians of the First Marine Battalion, 1898

By André B. Sobocinski, Historian, BUMED

As hostilities with Spain grew in wake of the USS Maine explosion in February 1898, the Secretary of the Navy John D. Long ordered the Marine Commandant to establish a Marine Battalion for expeditionary duty. On April 17, 1898, the First Marine Battalion was organized under the command of Lt. Col Robert Huntington. Included in the Battalion's headquarters staff were Navy physicians who are considered the first ever to deploy with a Marine expeditionary unit.

For much of the nineteenth century, Navy physicians did not "embed" with Marine units on deployments. Rather, a "Marine physician" in those first years of the Navy's existence was any medical officer assigned to a Marine Corps Barracks or Rendezvous who operated a dispensary or conducted medical examinations on new recruits. When Marines deployed, however, that Navy physician remained at the station.

The Spanish-American War prompted a new model for the "Marine physician" and the medical officers assigned to the 1st Marine Battalion were every bit proto-Leatherneck physicians.

Heading the Battalion's medical department was Surgeon John Marion Edgar, who served with Huntington at the Marine Barracks in Brooklyn, N.Y. The Philadelphia native and graduate of the University of Pennsylvania medical school was an 18-year veteran of the Navy who had

Painting showing Marines raising the American flag at Camp McCalla on June 11th, 1898. ***Navy History and Heritage Command***

Portrait of Medical Director (formerly Surgeon) John Marion Edgar, ca. 1912. Edgar served as the senior medical officer of the First Marine Battalion in 1898.
BUMED Archives

spent the majority of his career as a medical officer aboard steamers and receiving ships. As senior physician, Edgar oversaw the battalion's medical department which included an assistant physician, an apothecary (Samuel Rouse), five bay men (forerunners of hospital corpsmen), and even six musicians who doubled as stretcher bearers.

Acting Assistant Surgeon John Blair Gibbs served as Edgar's deputy medical officer. Gibbs was an Army-brat born in Richmond, VA in 1858. After attending the University of Pennsylvania medical school, Gibbs studied surgery in Vienna, Austria. He later settled in New York City where he served as the attending physician at the Demilt Dispensary, a charitable organization that specialized in providing medical care to the poor. Like much of the country, Gibbs was deeply affected by what had been seen (at the time) as a nefarious attack on the Maine and Cuba's fight for independence.

By the Spring of 1898, there was no doubt whether there was going to be a war with Spain. The only question was when it would be declared.

On April 24th—a day before the U.S declared war on Spain—Gibbs applied to become a volunteer physician with the Navy. And through family connections to the Assistant Secretary of the Navy—Theodore Roosevelt—Gibbs was accepted into service. He joined the First Marine Battalion on May 6th.

The Battalion landed on Guantanamo Bay, Cuba on June 10th and soon after established Camp McCalla (named after Rear Admiral Bowman McCalla, who was overseeing the naval blockade of Cuba). According to Edgar, the camp "faced the bay and was pitched on a hill some 190 feet in height."

Separate from the Spanish Army, disease was the greatest threat for the First Marine Battalion, and namely knowlesi malaria and acute dysentery. Edgar noted that patients suffering from the latter were given a mild purge, administered opium and lead acetate and put on a restricted diet for four days.

The Marines first began skirmishing with the Spanish on June 11th. The attacks on the camp became more fervent on the morning of June 12th. Assistant Surgeon Gibbs was taking care of wounded at the field hospital when firing become continuous and medical personnel began evacuating to evacuate the patients to a place of safety. Gibbs was shot 15 feet from the hospital while relocating patients, dying 30 minutes later.

Witnessing the attack on Camp McCalla on June 12th was the author Stephen Crane who was serving as a freelance war correspondent. In an article later compiled in his War Stories, Crane wrote, "I went in search of Gibbs, but I soon gave over an active search for more congenial occupation of lying flat and feeling the hot hiss of the bullets trying to cut my hair. For the moment I was no longer a cynic. I was a child who, in a fit of ignorance, had jumped into the vat of war. I heard somebody dying near me. He was dying hard. Hard. It took him a long time to die. He breathed as all noble machinery breathes when it is making its gallant strife against breaking, breaking. But he was going to break. It seemed to me, this breathing, the noise of a heroic pump which strives to subdue a mud which comes upon it intones. The darkness was impenetrable. The man was lying in some depression within seven feet of me. Every wave, vibration, of his anguish beat upon my senses. He was long past groaning. There was only the bitter strife for air which I held my own breath in the common unconscious aspiration to help. I thought this

man would never die. I wanted him to die. Ultimately he died. At the moment the adjutant came bustling along erect amid the spitting bullets. I knew his voice. 'Where's the doctor? There's some wounded men over there. Where's the doctor?' A man answered briskly: 'Just died this minute, sir.' It was as if he had said: 'Just gone around the corner this minute, sir.'" Gibbs was buried along with five Marines who were killed in the attack. Gibbs was briefly replaced in the headquarters staff by Assistant Surgeon Albert McCormick and later William Ford Arnold.

After four days of continual attacks, the Marines took the fight to the Spanish. On June 14th, the Marines attacked the Spanish Army and Cuban loyalists six miles away near Cuzco Beach (where the Spanish maintained their fresh water supply). The attack—supported by 50 Cuban insurgents and offshore by USS Dolphin— was one of the resounding victories in Marine history (and known as the Battle of Cuzco). Two Marines in this operation were later awarded the Medal of Honor.

The Marines broke camp on August 5th and left Cuba. Hostilities ended on August 12th with the signing of signing of a Protocol of Peace between the United States and Spain. The formal Peace Treaty, signed on December 10th, 1898, resulted in U.S. acquisition of the Philippines, Guam and Puerto Rico and protectorate status in Cuba.

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Photographs of Marines at Camp McCalla in June 1898. *Library of Congress*

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