NAVY MEDICINE

LEGACY

Issue 2, 2021

THE NAVY MEDICAL RETIREE DIGEST

NAVY MEDICINE'S FALLEN SAILORS
L to R: HM3 Maxton Soviak, HM2 Sarah Burns and HM3 Bailey Tucker

The Sacrifices of Service

By RADM Bruce Gillingham

Like many of you I watched the footage of the last plane leaving Afghanistan with a whirlwind of emotions. That C-17 lifting off at 3:29 pm (EST) on August 30th marked the end of our Nation's longest war. Over the last two decades our One Navy Medicine Team played an indispensable role providing frontline care pivotal in saving life and limb. From the immediate combat casualty care on the front lines of the battlefield and the role of FRSS/STPs to the 11-year command of the NATO Role III Multinational Medical Unit in Kandahar we succeeded in our mission to advance healthcare and surgical needs in an inhospitable environment.

For the past two decades Navy Medicine has continually answered our Nation's call and deployed forward to support our Sailors, Marines, and coalition partners in Afghanistan. Many of you have served boots on the ground in this long war as Individual Augmentees, on patrol with your Marines and Sailors, and embedded with Role 2 and 3 facilities in theater. During this 20 year period, you as members of Navy Medicine did incredible, heroic work. Those who served on the ground and those who supported our deployed members should be deeply proud of what they accomplished. . .

The Sacrifices of Service (cont'd)

You kept our Marines, fellow Sailors and Coalition forces safe by being the "Doc," ensuring the care and well-being of your units. Your preventive care and steady presence was paramount and when a casualty occurred you were ready. From the front lines a casualty had a 97% survivability rate; such success is unprecedented and highlights your incredible efforts. As the war changed, you adapted and persevered. What we learned in trauma care we applied in preparation for future conflict and shared with our civilian counterparts. These lessons help save lives on the battlefield and in our local communities every day.

Sadly, this hard-fought war cost this Nation some of its best and brightest. Some 2,461 American military personnel were killed in action in Afghanistan and over 20,000 wounded. Their names, life stories, sacrifice and devotion will remain with us. Reaching any closure is made more difficult with the tragic death of HM3 Maxton Soviak, a 22-year old Corpsman from Berlin Heights, Ohio killed in a terrorist attack at the Hamid Karzai International Airport in Kabul. We continue to mourn the loss of one of Navy Medicine's own, as well as the 11 Marines and one Soldier who also perished in the blast. We hope that in time the feelings of anguish will be tempered by the knowledge that they gave their all to protect people in need.

As our chapter in Afghanistan has ended, a new one has begun with the care for Afghan evacuees at DoD bases both stateside and overseas. DoD is providing temporary housing, sustainment and support—including medical care—to over 100,000 fleeing Afghans, both young and old. Members of our Navy Medicine team have reported to Marine Corps Base Quantico, Joint Base Fort Dix, Fort Pickett, Camp Atterbury, Indiana, US Naval Air Stations Rota and Sigonella, as well as special camps in Bahrain and Kuwait to screen evacuees for COVID-19, provide vaccinations and medical care, where needed. As this mission continues to develop, we expect other medical personnel will be called upon to support this mission in the coming weeks and months.

Each and everyday members of our military families go into harm's way to protect and preserve our vital national interests. We deploy forward and work in dangerous environments. We are members of the profession of arms. We knowingly risk our lives to serve others, and understand we may be called up to make the ultimate sacrifice.

On September 4th, the Navy announced the names of those lost in the MH-60S helicopter crash off of San Diego. Among those five crewmembers were two of Navy Medicine's own–HM2 Sarah Burns of Severna Park, Md., and HM3 Bailey Tucker of St. Louis, Missouri. To all those who knew them and served beside them, Sarah Burns and Bailey Tucker are more than names. Both have been described as compassionate individuals who joined the Navy with a desire to give back.

Inspired by her paternal grandfather's service, HM2 Burns enlisted in the Navy in 2010. She spent those first years as an aircraft mechanic with Helicopter Mine Countermeasures Squadron 14, Helicopter Sea Combat Squadron 84, and Helicopter Sea Combat Squadron 85 before deciding to cross-rate and become a Search and Rescue Medical Technician. HM2 Burns became a fully qualified Corpsman in November 2020 and was assigned to the Helicopter Sea Combat Squadron Eight.

HM3 Tucker's path to Navy Medicine was shorter, but he too shared Burns' goal of serving a greater cause. He enlisted in 2019, a year out of high school. For Tucker, being a Corpsman and having the chance to serve others and save lives was his life's calling. Serving with Helicopter Sea Combat Squadron Eight afforded him this opportunity to do what he loved.

Each and every day we rely on highly trained Sailors like Sarah Burns and Bailey Tucker to take on demanding missions, keep us operationally ready and ensure that our warfighters remain in the fight. They represent the very best of America; less than one percent of our fellow citizens have volunteered to serve in the military. And as we have been painfully reminded with their tragic deaths, service does not come without risk, even far from active combat zones.

Although their lives came to an end much too soon, they shall be remembered as shining examples of devotion to duty and service to others. Please hold them and their families in your thoughts, prayers, and hearts.●

NAVY MEDICAL LEGACY

A RETIREE DIGEST

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EDITOR'S NOTE:

Navy Medicine Legacy is digital publication for the Navy Medical retiree community. We would love to know what topics and themes you are interested in us covering in order to meet your information needs. We also welcome all story ideas, news items and articles for inclusion in future editions. To share feedback please contact our editorial team at:
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NAVY MEDICINE-PENN PRESBYTERIAN PARTNERSHIP

Navy Surgeon General RADM Bruce Gillingham and Kevin Mahoney, Chief Executive Officer for the University of Pennsylvania Health System, hold the signed agreement that starts a three-year partnership to integrate members of the Navy with the Trauma Division at Penn Presbyterian Medical Center (PPMC). The program, known as Naval Strategic Health Alliance for Readiness and Performance is designed to provide sustained experiences in all aspects of trauma care – from surgery to anesthesiology to nursing – in one of the nation's busiest trauma centers.

Photo by Captain John Gay

NAVY MEDICINE LAUNCHES PARTNERSHIP WITH PENN PRESBYTERIAN TRAUMA DIVISION

By Ed Gulick, Deputy PAO, BUMED

Representatives from Penn Medicine and the United States Navy signed a unique agreement on September 9, 2021 marking the start of a three-year partnership to integrate members of the Navy with the Trauma Division at Penn Presbyterian Medical Center (PPMC). The program, known as the Naval Strategic Health Alliance for Readiness and Performance, is designed to provide sustained experiences in all aspects of trauma care – from surgery to anesthesiology to nursing – in one of the nation's busiest trauma centers. The eleven Navy team members bring a wealth of experience with multiple deployments around the globe that will promote new approaches and knowledge across both civilian and military healthcare.

The agreement will be signed at a ceremony by Kevin B. Mahoney, Chief Executive Officer of the University of Pennsylvania Health System, and Rear Admiral Bruce Gillingham, Surgeon General of the Navy.

"This partnership will work to develop a blueprint for other future partnerships between the military and civilian health systems, and will be of great benefit to both parties," said C. William Schwab, MD, the Founding Chief of Penn Medicine's Trauma Program, a professor emeritus of Trauma Surgery, and a veteran of the Navy himself. "Penn Medicine's Trauma Division is incredibly talented at training interdisciplinary teams in order to provide the best possible care to patients, and the U.S. Navy team will be fully immersed in all aspects of practices and specialty units. We're eager to collaborate with the Navy and on groundbreaking research that will advance how we care for patients and improve outcomes, both in the hospital and on the battlefield."

"The Navy medical team greatly appreciates the support from the University of Pennsylvania Health System. Trauma care in a deployed combat environment can be challenging at best and preparing for and keeping such skills up to date is difficult as garrison military treatment facilities simply don't see the type of cases or urgency a trauma team will experience when deployed," said RADM Gillingham. "This Navy team will learn invaluable lessons that they will bring back to the Navy Medicine that will help them and us better understand and prepare for future deployments."

The Navy team closely matches the makeup of the surgical teams the Navy deploys to active combat, with three physicians, three nurses, a physician's assistant, two Hospital Corpsmen and a healthcare administrator. They will integrate into the PPMC Trauma Division and the academic clinical departments – such as Surgery, Anesthesia, and Emergency Medicine – to gain intensive training in treating traumatic injuries from leading experts at PPMC to ensure that their skills are at the highest possible level when they deploy. Navy team is will relocate to Philadelphia with permanent change of station orders for approximately three years.

"This is truly an incredible opportunity for Navy Medicine, and our entire team is excited to be part of this new venture with Penn Medicine," said Lieutenant Commander Bill Lawson, the trauma team's administrator. "It's a program that will shape the future on how we train as military medicine personnel, and will ensure our medical forces have the trauma skills and experience necessary to deploy in more austere environments"●


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A NAVY NURSE AND A DOG NAMED "MINDA"

By Cynthia Coyle, CDR, NC, Ret.

Everyone loves puppies; but some puppies are simply more special than others. With dedicated staff, volunteers and donors, a pup can become the most valuable gift that a disabled veteran may ever be given.

Warrior Canine Connection (WCC) is a nonprofit that breeds, trains and places highly specialized service dogs with Service Members and Veterans with visible and invisible wounds. Warrior Canine Connection uses a Mission Based Trauma Recovery (MBTR) training model that harnesses the healing power of the Warrior Ethos and the human-animal bond to reduce symptoms of combat trauma whereby Warriors with combat stress train the dogs to assist another Veteran with visible and/or invisible wounds. The model provides Veterans with a sense of purpose while they are recovering and is designed to remediate their symptoms of combat stress, such as isolation, emotional numbness and re-experiencing. Each dog can positively impact up to 60 Veterans during the training process.

Each WCC future service dog is named for fallen or inspirational Veterans through a nomination process. This brings awareness to the namesake's service while helping to heal the invisible wounds of recovering warriors.

The Navy Nurse Corps Association (NNCA), a nonprofit organization whose members include active duty, retired, reserve and former Navy nurses is a partnering organization that submits namesake nominations.

Submitting the namesake nominations documents the life and Navy career of inspirational Navy nurses and supports the NNCA goal to the preserve of rich history and the traditions of the Navy Nurse Corps. For NNCA membership and mission, see www.nnca.org

At roughly three months of age, each puppy is placed with carefully selected "puppy parents." These special people make the commitment to care for the dogs in their homes until they are approximately two years old. Many of these volunteers are staff members at DoD and VA medical facilities who bring the dogs to work every day. There, the dogs work with wounded Warriors who are participating in therapeutic service dog training programs.

When each dog has completed their training and health screenings, they are paired with Veterans with visible and invisible wounds. The therapeutic service dog training program harnesses the healing power of the human-animal bond and the NNCA provides namesake nominations that recognize the service of the Navy nurse for whom the pup is named.

In future issues, those Navy nurses who have been selected as namesakes for Warrior Canine Connection pups will be featured.

The pup "Minda" was named in honor of Geraldine Araminda Houp, CAPT, USN, RET.

CAPT GERALDINE ARAMINDA HOUP

Navy nurse CAPT Houp died in 2019 at the age of 101. After her passing service dog "Minda" was named in her honor.

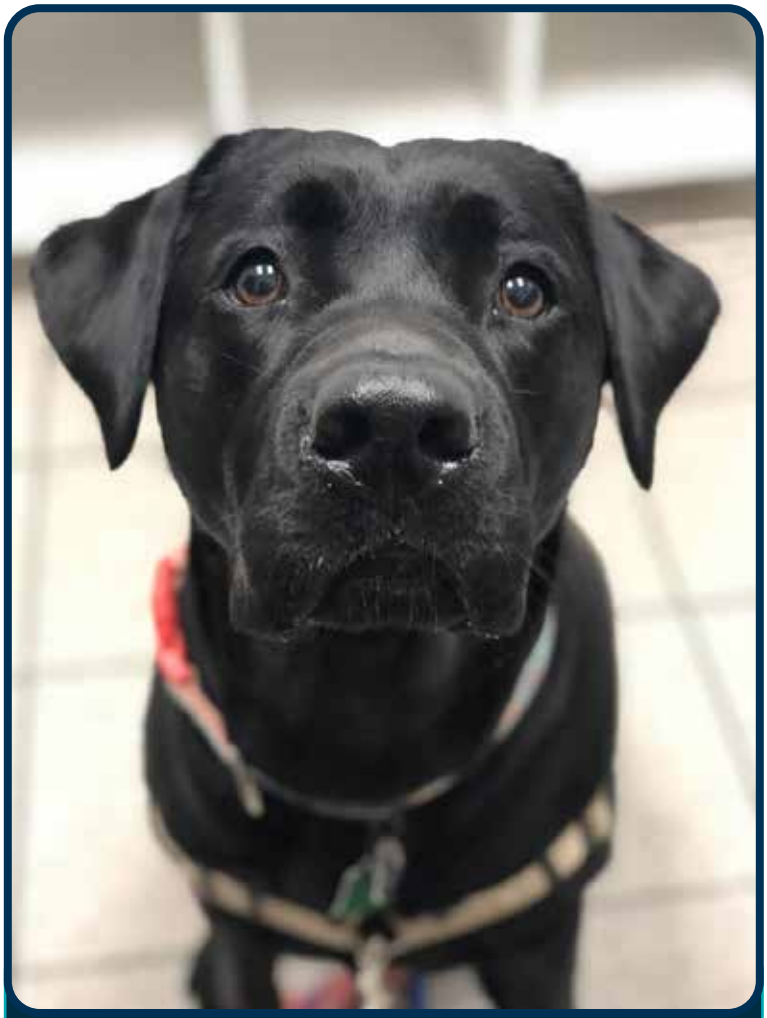
Geraldine Araminda Houp was raised on a 60-acre farm near Oley, Pennsylvania. Her interest in the military began in nursing school when CAPT Houp was tasked with writing a paper about one of the military services and the Red Cross. CAPT Houp chose to write about the Army and then participated in a three-month orientation. While she did not develop an immediate interest in serving, she was later intrigued when meeting several Navy Nurses at an on-campus event.

CAPT Houp's decision to serve came somewhat unexpectedly. It was 1942 at the height of World War II, when a girlfriend who was intent to serve, asked CAPT Houp to accompany her to a recruiter's office. While in the recruiter's office, CAPT Houp felt inspired to serve and she too completed an application and was ultimately accepted. "It was World War II and everybody wanted to do their part!," CAPT Houp later recalled.

At the time, CAPT Houp had been working for two years as a civilian nurse at George Washington University Hospital. Her service in the Navy Nurse Corps, which spanned from 1942 to 1969, would take her all over the world. CAPT Houp served in hospitals and clinics from Panama, to Sasebo and Yokosuka, Japan. She was stationed in USNH Trippler in the evacuation wards, and then transferred to Guam when the Korean War began. Her service throughout the United States included time at the USNH Annapolis, USNH Philadelphia, the Bureau of Medicine and Surgery, Washington D.C., USNH Jacksonville, USNH NY/Queens, USNH Stanford/Lake Geneva, a Navy Unit at Army Hospital Fort Eustis, and USNH Camp Lejeune.

CAPT Houp last worked at St. Albans Naval Hospital, before retiring in 1969. Her rank of Captain made her one of the highest-ranking female military officers in the United States armed forces in her time. Her service as a Navy Nurse spanned from World War II, to Korea, to Vietnam. For her twenty-seven years of service to our country and for her role in treating and saving thousands of military lives, the puppy Minda was named in her honor.

CAPT Geraldine Araminda Houp passed away on December 8, 2019 at age 101. ●



ABOUT WCC'S MINDA

"Minda," a member of Warrior Canine Connection's Operation Overlord Litter, was born in June 2019. She completed her initial training with her loving Puppy Parent Michele Burkhammer, and was deemed best suited for WCC's breeding program. The program is an important initiative to ensure the health and longevity of WCC's future service dogs. Her favorite things are playing with Shelly, her service dog in training sister, taking long walks in the woods, eating and napping. We hope to have good news to report about an upcoming expected litter--stay tuned!

To learn more about the Navy Nurse Corps Association mission and membership, visit:
www.nnca.org

To learn more about Warrior Canine Connection, visit:
www.warriorcanineconnection.org

NAVY MEDICINE SUPPORTIVE CARE FOR ALABAMA HOSPITAL CAREGIVERS

By Doug Stutz, PAO, NMRTC Bremerton

There's a hand-painted sign announcing "Heroes Work Here" outside of Dale Medical Center in Ozark, Alabama.

The personalized statement is as much a reference to the over-worked staff as it is to the U.S. Navy Medicine team who deployed there in early September, 2021.

A active duty team of nurses, providers and hospital corpsmen has been sent into Alabama as part of continued Department of Defense COVID response operations in conjunction with Federal Emergency Management Agency (FEMA) to offer support to help deal with the spread of COVID.

"We're part of DoD's ongoing COVID operations to support FEMA and the state of Alabama," said Lt. Cmdr. Andrew Rutledge, the officer in charge of Navy Medicine Readiness and Training Unit Everett. "We're all proud to be part of the whole-of-government response and increase the medical capacity to care for COVID patients that have taxed local community assets."

According to local reports, hospitals throughout southwest Alabama are trying to accommodate providing care for patients beyond normal intensive care unit (ICU) capacity. Just two days before the Navy Medicine team arrived, approximately 2,775 new patients were admitted for care across the state. Many of these hospitalizations are attributed to the Delta variant of the virus.

Vernon Johnson, the Dale Medical Center chief executive officer, delivered a stark reminder on the current concerns of an overwhelmed staffing trying to stop the spread of the pandemic and deal with increased COVID cases.

"Now's not the time to have a heart attack or a major car wreck, or something serious because there is nowhere to send you," said Johnson while addressing local media outlets.

The Navy medicine response team arrived Sept. 6, 2021 to relieve pressure on the hospital and its staff. There are 16 from Naval Medical Center San Diego, two from Navy Hospital Twentynine Palms, one from Naval Hospital

NAVY COVID CARE IN A CIVILIAN HOSPITAL

Hospital Corpsman 2nd Class Tessa Hazard (right), a respiratory therapist assigned to the Navy Medicine Readiness and Training Command (NMRTC) Bremerton, Wash., treats a patient in the Intensive Care Unit ward of the Dale Medical Center in Ozark, Alabama, Sept. 9th, 2021. She is a part of a larger effort in support of continued Department of Defense COVID-19 response operations. U.S. Northern Command, through U.S. Army North, remains committed to providing flexible U.S. Department of Defense support to the whole-of-government COVID-19 response.

Photo by Sgt. Aaron Daugherty

Lt. j.g. Kaitlyn Liebing, a nurse assigned to the Navy Medicine Readiness and Training Command (NMRTC) from San Diego, California, analyzes data alongside a hospital staff member while caring for patients in the Emergency Room ward of the Dale Medical Center in Ozark, Alabama, Sept. 9th, 2021. She is a part of a larger effort in support of continued Department of Defense COVID-19 response operations. U.S. Northern Command, through U.S. Army North, remains committed to providing flexible U.S. Department of Defense support to the whole-of-government COVID-19 response. Photo by Sgt. Aaron Daugherty

Camp Pendleton and four from Navy Medicine Readiness and Training Command (NMRTC) Bremerton; Lt. Cmdr. Andrew C. Rutledge, Lt. Candice Carter, Lt. Adeline Guina and Hospital Corpsman 2ndClass Tessa Hazard, one of two corpsmen with specialized skills as respiratory therapists .

"Our job is to support FEMA and the state of Alabama to provide medical assets in the COVID response," said Rutledge, a 16-year Navy Medical Service Corps officer from Sarasota, Florida.

Rutledge, as Navy Medicine Readiness and Training Unit Everett officer in charge (OIC), is handling operations officer responsibilities to assist coordination of the daily operations for both military and community medical assets to ensure the mission is accomplished.

"I will assist the OIC in administrative and operational duties to maximize our clinical staff's proficiency in patient care," Rutledge said. "I'm thrilled to be supporting my fellow citizens and to help alleviate suffering from the pandemic."

Rutledge and others began their mission with a familiarization briefing to learn the local hospital guidelines and mission, background information and insight on the local surrounding community. Four days after their arrival, they began working side-by-side with their civilian colleagues.

Twelve hour days – at minimum – are now the norm for the team. They've been helping provide care for COVID and non-COVID cases in the ICU, multi service unit and emergency room. The ICU, being full, is the busiest. When a bed does open up, it is quickly filled. Dale Medical Center has all but rolled out the welcome mat in their appreciation for the DoD medical professionals.

"They have been outstanding and extremely thankful

for our help. We are enjoying a lot of southern hospitality," said Rutledge, noting that all Navy personnel have been adaptable in fitting into their new working environment.

"Although not the same as where many of the team members come from, the Sailor's prior experiences in many different medical treatment facilities and deployments in unique environments over the years make adaptation more of the norm for us," Rutledge continued. "Many of the staff have been working at Dale Medical Center for 30 years or more. Our goal is to acclimate to their schedule and be like them as much as we can in how they support their community."

There are five military bases in Alabama, including Fort Rucker located in Dale County, but none belonging to the Department of the Navy. As such, the Navy uniform and insignia have caught the attention of the locals.

"When we have had the opportunity to have meals and such while in uniform in the local area, our staff have been well received and thanked for their service both for what they normally do and what they are doing today" said Rutledge. "In speaking with the manager at the Dairy King who noticed our uniforms, she commented her thanks and how folks in her town really need the help and how much it has affected the community,"

As in any deployment, there are some days which are more trying than others. For over a year and half, dealing with the pandemic has taxed many, if not all, in most clinical settings. Rutledge affirms he understands the adversity and complexity the Dale Medical Center staff has had to handle, yet still they persevere in caring for those in need.

"Seeing the loss that many of the local staff have had to endure these past 18 months, and the challenge ahead in preventing more has been difficult for them," observed Rutledge, adding that it has been gratifying to see Navy medicine working well alongside the hospital and "strong Alabama National Guard support."

The Navy Medicine team's mission is open-ended with no definitive end date. Yet.

"Our team is very honored, humbled and we're excited to be part of this holistic approach to responding to the crisis. We look forward to working alongside the Dale Medical Center staff providing medical support and treatment to our fellow Americans in this local community during this time of need," said Cmdr. Maggie Parks, team lead. ●

NAVY MEDICAL RESPONSE TEAMS AIDE CIVILIAN HOSPITALS

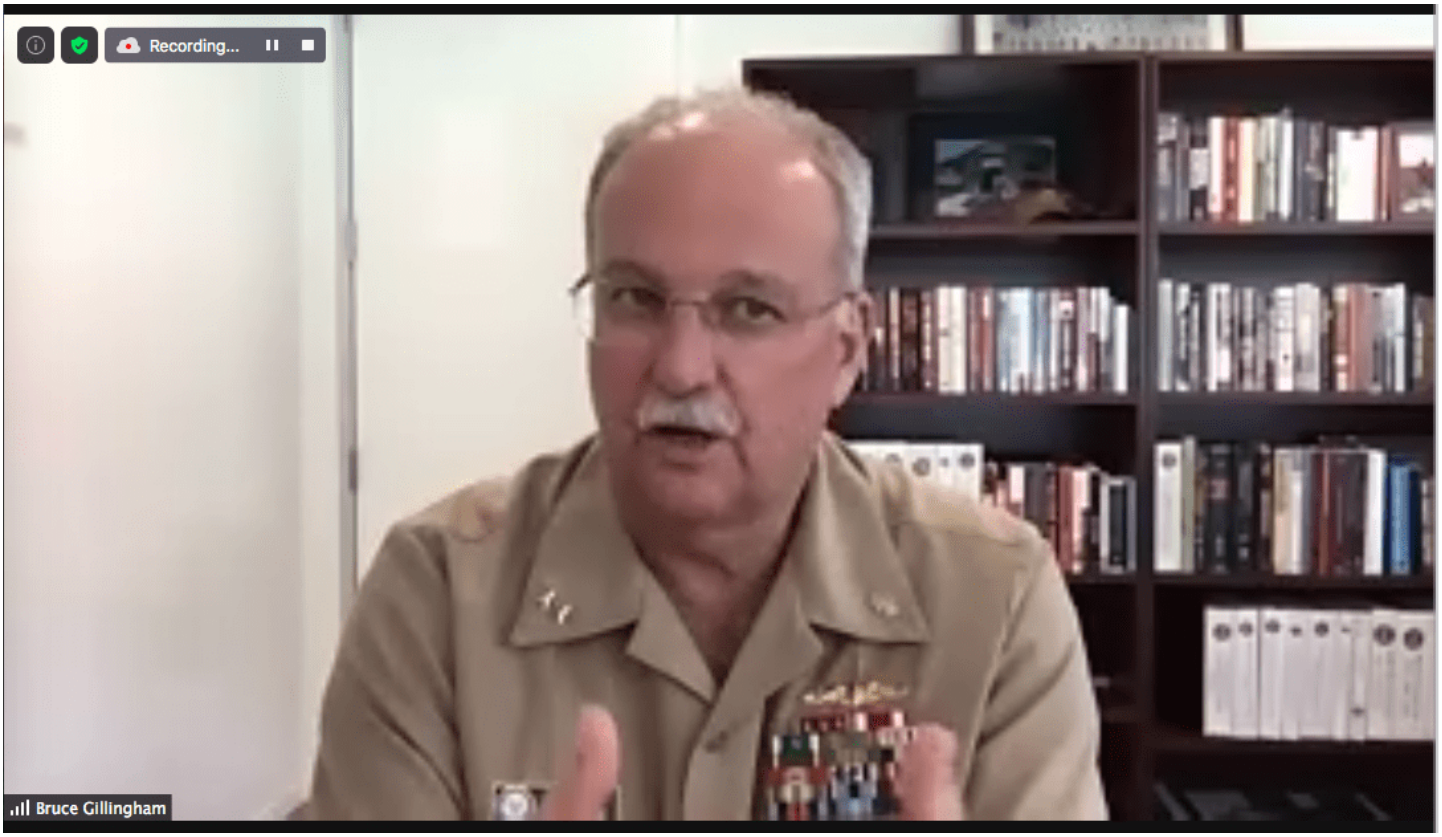
At the request of the Federal Emergency Management Agency, approximately 60 military medical personnel deployed in three, 20-person teams, each to one of three states – Idaho, Arkansas and Alabama – to support civilian healthcare workers treating COVID-19 patients in local hospitals.

These three teams join six other teams currently working in six hospitals – three in Louisiana, two in Mississippi, and one in a different Alabama city.

U.S. Army North, under U.S Northern Command's oversight, will provide operational command of the active-duty military COVID-19 response in support of federal efforts and the states.

In August, the Navy deployed a team to Ochsner Layfayette General Medical Center in Lafayette, Louisiana and in September sent a 20-person team to the Dale Medical Center in Ozark, Alabama. ●

DEFENSE WRITERS GROUP HOSTS THE SURGEON GENERAL



On August 19, 2021, the Defense Writers Group (DWG), an association of defense and national security correspondents with 50 member news organizations from around the globe, hosted Rear Adm. Gillingham for a discussion about Navy Medicine today. The following is a transcript of from this event.

MODERATOR: Welcome everyone, especially in this incredibly busy news cycle. We'll keep an eye out for late arrivals given the Pentagon press conference this morning and filing.

Welcome to our session of the Defense Writers Group. We are so honored to have Rear Admiral Bruce L. Gillingham, the Surgeon General of the United States Navy. I'm Thom Shanker, the Director of the Project for Media and National Security. And as many of you know, I conducted a poll early after I took over this job and one of the interesting findings was how many of you requested more of these sessions not only focusing on operations and policy, but more on health of the force and personnel matters. So Admiral, we are really honored that you are the first member in our expanded agenda program, sir.

RADM GILLINGHAM: Thank you, Thom. It's a pleasure to be here.

MODERATOR: I'll use my role as benign dictator to ask the first question, and any of the correspondents who are on-line who want to ask questions, please drop me a note in the direct chat and I will certainly call on you.

Admiral, to start the discussion kind of at the top line level here, sir, the past 18 months have been a challenge for the medical community, in the Navy, across the armed services, quite literally around the globe. I'd be

curious what lessons you are taking now as the Navy's Surgeon General of infections aboard the Roosevelt and the Kidd, how you have kept the Navy readiness at the high level that you have, and what you will do to reshape naval medicine going ahead to protect the health of the maritime service. Not just against pandemics, sir, but against the entire range of threats facing the nation and the Navy.

RADM GILLINGHAM: What a great question.Certainly when I came into office the 1st of November of 2019, it was very apparent to me that we faced new challenges. Certainly the great power competition introduced new medical challenges. As the Navy Surgeon General, obviously I'm responsible for the force health readiness of both the Navy and the Marine Corps.

Before I took over I had a bit of time to think about those challenges and recognized that in a peer competition we'd be facing challenges that we did not face in the desert. Chief among them the tyranny of geography, of large distances, and frankly, the inability probably to maintain that same ability to provide surgical care immediately upon wounding that we had in the desert.

I was in Iraq in 2004 just outside of Fallujah, and many of the patients that I got not only met the golden hour but actually were there in what we called the platinum ten minutes, so we were able to respond to them immediately. So looking at how we are able to provide medical care in that distributed maritime environment really is critical.

My job before Surgeon General was in the Pentagon developing future medical capabilities so I had a lot of time to think about that. We recognized, consistent with the CNO's guidance on distributed maritime operations and the Commandant's guidance on expeditionary advanced basing operations, that we were going to need to have smaller teams more widely distributed across the AOR. So we were able to leverage some of those small unit lessons that we learned, particularly about damage control surgery in the desert, to transport that to the shipboard environment.

So we actually have small what we call Emergency Resuscitative Teams shipboard and we will continue to work that model. There's a gap, though, because as you know, in combat casualty care we always seek to move the patient up-echelon to definitive care as quickly as possible. In that environment, there's a gap because of those long distances and I'm excited to say that we've had the opportunity to help develop what's known as the EPF Flight 2. So really the Expeditionary Fast Transport. This is the vessel that previously was primarily used for logistics purposes. The Joint High Speed Vessel. Austal is now working on one that will have changes, significant structural changes for medical. So it will have a flight deck that will land an Osprey, for example. We'll have space to run two operating rooms, an 18-person, 18-bed ICU, and the vessel will actually feed and berth a medical staff of about 100. So what we call a Role 2 Enhanced Medical Capability. So we're very excited about that.

Of course our hospital ships, the *Mercy* and the *Comfort*, have been our Marquis platforms. But frankly, would not be able to cover the ground or get as close to the fight, if you will, that we envision the EPF. So we think that's filling a critical gap and we're excited to work the concept of operations using that. And to work with the Marine Corps as they work on force design, to think about how we're going to provide medical care to them as they seek to be highly maneuverable, even more so than they are now, and be able to provide Role 2 care in that setting. That's kind of an overview.

The other piece of that, and to go to your initial point, COVID taught us and reminded us that in any conflict it's disease non- battle injuries that actually produce the highest volume of casualties. So in addition to the combat casualty mission, we've got to be able to operate in that contaminated environment, if you will, and we've got to be able to take care of those individuals who are not combat wounded but who are ill or injured.

And we've learned a lot from COVID. You mentioned the Roosevelt. Our teams were on site and we actually had anticipated that TR would be at risk so we had placed a forward deployed preventive medical unit aboard that had COVID testing capability. They were actually able to identify that in fact it was SARS CV2. And so that taught us a lot about how we're going to have to augment our ships to be able to operate in that environment. I'm very pleased to say that based on the extensive outbreak investigation that occurred both on *TR* and the USS *Kidd*, that we were able to actually publish in the New England Journal last year the findings of that outbreak investigation. And that was really, to my knowledge, the first large study demonstrating that the virus' stealth weapon, its secret weapon is asymptomatic and presymptomatic transmission. So we learned a lot from that.

But it also emphasized, again, in addition to the combat casualty care piece, we've got to be able to operate in a contaminated environment. And then I will just say, a key success factor following *TR*, the fact that we've been able to keep operating has been really the very close relationship that my experts and I have with the line leadership so that we can help inform guidance to help them operate in as COVID-free an environment as we can achieve. And then that we're continually updating that. Continually building on that guidance.

But fundamentally I think the key success factor has been the resilience of our sailors and marines operating in difficult conditions, operating in these additional medical restrictions that we placed, and yet still getting the job done.

MODERATOR: The popular press, including my alma mater, *The New York Times*, have been running stories saying that COVID is here to stay, at some level or another, just like seasonal flu, other illnesses and all that. So what will the Navy have to do to maintain readiness if COVID is the part of the life of everyday citizens and of all of your Sailors and Marines? Do we have to look at pre-deployment quarantines in a new way? Tell us how you plan for this in the mid-term and not just for tomorrow.

RADM GILLINGHAM: I think it speaks to the absolute importance of a high vaccination level because we've found that shipboard when we have a very high vaccination level, we're not seeing significant outbreaks, and if individuals become ill, it's really more akin to a cold or a mild flu as opposed to severe illness.

So I think if we continue to operate we'll make sure that our crews are highly vaccinated. Of course we have a mandate coming up which we're looking forward to, because it will just contribute to what our main job is as far as health protection. I think we'll learn what we've learned from the non- pharmaceutical interventions that we've been able to carry out aboard ship. Those will probably become standard practice. As well, I'm encouraged that I think our detection ability, our laboratory detection ability will improve so that early on when we do see elements like we did with the *TR*, we'll be able to diagnose early and practice those quarantine and isolation techniques that have worked thus far.

MODERATOR: Thanks, Admiral.

The first question from the correspondent corps is Jeff of *Navy Times*.

DWG: Thanks so much, and sir, thanks so much for taking time to speak with us today.

I'm just wondering if you can offer any fresh insight into the mandatory vaccination plan for the Navy and Marine Corps, how that's going to work, what Sailors or Marines who still decline the vaccine might face in terms of discipline, and if you have an updated number of sailors and marines that are fully vaccinated, I'd take that as well.

RADM GILLINGHAM: I would say that based on all that we've learned during initial vaccination operations while it's been voluntary, that we'll be in very good shape. We are confident that we're going to have an adequate amount of vaccine. We've learned how to be able to give it aboard ship and in a more remote location. So I'm confident that we'll be ready to go.

In terms of those who decide even though it's a general order and required, obviously that will be handled administratively and I will leave that up to the line in terms of how that will happen. But I think frankly, I think our sailors and marines will understand that it's at this point been deemed a mandatory readiness requirement and I don't think we're going to face significant resistance, frankly.

There's also the issue, I would just add, that we will certainly be attentive and responsive to medical exemptions. Right now because the mRNA vaccines are synthetic, I don't think we're going to see a significant number of those either.

Right now the two scenarios that I can imagine would be someone who is so severely immuno-compromised that they can't take the vaccine. That's obviously going to be a very small number in our active duty and would be handled by the physicians caring for them. The other is just a documented history of having had an allergic reaction to either the first or second vaccination.

Then in terms of where we are, I think we're doing very well. Navy is well over 72 percent immunized, that is having gotten both doses or completed a series, one dose if it's J&J. The Marine Corps has some work to do but they're making progress and I think they're in the high 50s at this point.

DWG: We're hearing from a lot of service members about what they may face. Just in your experience, and I know you're a medical guy, but do you see this being like a courts martial situation, an NJP situation, a counseling chit. What do you think discipline, and I know you are medical but I imagine you kind of have some cognizance over how that's going to work. Can you kind of give us an expectation of what the rank and file might expect if they do in fact go against this general order?

RADM GILLINGHAM: I think what's going to happen is we'll go back to the counseling. We'll sit down with the individual, try to understand the source of their resistance, and address that.

Ultimately I would hope that any NJP or legal proceedings would be very late in that continuum. Again, I think when they realize that yes, the Secretary of Defense has made the determination based on expert guidance that this is required for mission readiness, I do believe that those that still haven't gotten the vaccine will see the value and will proceed with getting it.

MODERATOR: Next will be Rick Burgess of *Sea Power* Magazine.

DWG: Thank you.

With the 2022 budget submission, what can the Navy and Marine Corps expect in terms of increase or decrease in capacity of medical care, including the care for families and retirees?

RADM GILLINGHAM: I can tell you that obviously we submit our requirements and work through the POM process. Obviously since it has not been submitted as the President's budget I can't speak to specifics. But we continue to demonstrate the value that we provide to the warfighter as a critical enabler.

I mentioned at the outset the role that we'll play in distributed maritime operations. I do make the point that in this peer fight that the medical requirement for Navy will be more than they're probably used to in the sense that the Marine Corps has clearly seen the value that we provide.

So it's my job as the Surgeon General and those venues, those POM discussions to demonstrate the risk mitigation that we can provide. I like to say that our job is to provide medical power for naval superiority and I think that's a message that resonates. In terms of continuing to provide the family health care benefits, obviously that's an extremely high priority for the Department of Defense and we will continue to do that as a no- fail mission.

MODERATOR: Next question is Rebecca Torrence of *Bloomberg*.

DWG: Good afternoon, sir. Happy to be here.

I have a question about booster shots in light of the Biden administration's announcement yesterday to allow boosters for fully vaccinated adults eight months after their second shot. So given this news in the context of the DoD's vaccine mandate, how are you thinking about how booster distribution could occur throughout the Navy and Marine Corps and whether or not these boosters could be added to the mandate at some point in the future as we're seeing greater concerns floating around about breakthrough infections.

RADM GILLINGHAM: Thanks Rebecca.

We'll obviously follow CDC guidance as we have throughout COVID. So it will simply be a timing issue. Right now as I understand Dr. Walensky's and the CDC's recommendation. It's eight months after you completed the vaccine series. The data is not out yet for Johnson & Johnson, so obviously we'll follow that guidance as it emerges. But we will use our time tested methodology for making sure people get their vaccines on time. So we'll know when they got their terminal dose of the initial series, and we'll work to create a process by which they're notified and brought in at the eight month mark.

So I don't foresee significant challenge there. In fact as we start our flu campaign in the fall, I think there will be an opportunity to be even more efficient. And for those who got the vaccine early say in January or February, to phase the booster at the same time they come in for flu, so we'll work through those details, but immunizations is something that we do very well, as you know, and I'm confident in our team.

DWG: To clarify, so you're not thinking at the moment about the potential for adding boosters to this mandate that we're seeing for mid-September?

RADM GILLINGHAM: I think it will be semantics, Rebecca. Once a vaccine is mandated then any additional that would naturally follow from that would be included. But we certainly, if there's clarification or guidance needed obviously I think we'll generate that.

MODERATOR: The next question is to Patricia Kime of *Military.Com*.

DWG: Thank you, Admiral.

I'm wondering if you can give us an update about the manpower requirements for Navy Medicine. What is the status of the reductions that were expected out of the DHA reorganization and how many positions total have been cut, how many are going to be cut, what is the right size for that?

RADM GILLINGHAM: To date, no reductions have occurred. You're probably aware that after the initial reductions were proposed, the NDAA language prohibited that and so Congress received significant analysis from DoD. That process is ongoing.

I would tell you that it's been very healthy within the Navy and Marine Corps, we're going back and reviewing our analysis and of course a few things have changed since that initial proposal. COVID occurred. I mentioned in the opening question that we understand and have reinforced the value of our preventive medicine, public health assets. So we're going back and taking a look at that requirement. So this will be an ongoing process.

Obviously we want to make sure that we're able to meet mission and that our leaders understand whatever risk they may incur with the proposed cuts. But we've got a very collaborative process going on within the Navy and the Marine Corps to get to the right number, but that number has not been finalized to date.

DWG: Do you foresee when you might embarking on these reductions or when the analysis will be complete?

And a follow-on for that would be where do you see maybe adding a type of providers or personnel based on what you know from the analysis at this point?

RADM GILLINGHAM: Like I said, the analysis is ongoing. It won't be until -- no reductions would occur until Congress has received and approved the analysis. So at this point that's open-ended. As always, given that we support the Navy and Marine Corps, we tend to focus on what are known as critical wartime specialties, but we also have to acknowledge that many of our MPFs are in more remote areas. So as the Defense Health Agency assumes authority, direction, control of those MPFs, we will continue to support them to make sure that those MPFs have the full range of medical specialists that are required to meet the need in that area that can't otherwise be met either within the network or by hiring civilian professionals.

MODERATOR: This question is sort of out of the blue, but you talked about other risks, how to maintain the health of the force against nuclear competitors and all that. I wonder if you could speak for a minute about the sort of growing assessment that climate change is a belatedly recognized national security risk and whether you as the Navy's top medical officer are pondering the implications there. One example, I know this sounds like science fiction, but the maritime services are up around the polar ice cap. As it's melting we're reading stories about viruses that might have been frozen for eons becoming free. I know that's a science fiction scenario, but are there any real world implications for climate change on the important work that you do?

RADM GILLINGHAM: Obviously our new Secretary of the Navy has made that one of his four top priorities, so if he's interested we're fascinated, as you know. I think for us probably the area where, in addition to the role of potential emerging diseases as the environment changes and perhaps new pathogens appear, we'll continue to reinforce our surveillance of emerging diseases.

You may not know that our Navy medical research labs around the world are part of a global emerging infectious disease network that includes the WHO and the CDC. So we'll continue to be very vigilant there.

The other area where I think there's an overlap with Navy medicine is in our global health world and in our responses to disaster relief around the world. So if there are areas that need assistance there in which the Navy can appropriately assist, then certainly Navy medicine will support that.

MODERATOR: Patricia?

DWG: 43,000 sailors have contracted COVID and I'm trying to get a sense of whether they are all fully recovered, or do you have a certain percentage that really have had long COVID? And can you discuss the implications of that?

RADM GILLINGHAM: That's a great question, and that's an area -- one of the real values of having a Defense Health Agency is that we're able to kind of keep track of those folks that have sustained COVID illness.

We're seeing low numbers, long-haul COVID. I think for me, since I mentioned that obviously we're very interested in readiness, particularly the symptoms of prolonged fatigue and that can imperil someone's ability to respond to their mission. So we're making line commanders away that a sailor that has had COVID could have prolonged fatigue and that should be recognized as a valid concern, that they're aware of that.

Obviously we're following the science closely. We're making sure that we're out putting people into extreme environments before they're ready, and making sure they're medically cleared to do that.

So I think that's a great question. It does have military readiness implications and our experts are closely following the data to see where those might intersect with what we do.

MODERATOR: Rebecca Torrence?

DWG: A quick follow-up on that because I think it's a super interesting issue. Long COVID now can be classified as a disability under the ADA and I wonder how you're thinking about -- obviously there's the issue of how these symptoms might affect a service member's ability to complete their mission, but could this be grounds for medical disqualification? Would those symptoms have to last for a certain period of time or be of a certain severity? How are you considering those issues right now?

RADM GILLINGHAM: That's a great question. As you know, we have a well-established limited VA disability policy or standard operating procedure. So we would handle those as we would any diagnosis on a case by case basis. As I mentioned, our medical specialists are staying on top of the data. There are some very challenging diagnoses within long haul and it's our practice, obviously, to give the individual the appropriate amount of time to recover and return to active duty. Should that not be possible then we want to make sure that they in transitioning their care to the VA, that they'll get all of the care that they need to address those conditions.

MODERATOR: Admiral, this has been an extremely informative discussion. So important. I would like to return the floor to you for any final comments or thoughts you might like to share with us today.

RADM GILLINGHAM: Thank you, Thom.I really appreciate the interest.

As you mentioned at the beginning, this has been a challenging period but if there's a silver lining I think that COVID and the challenges that we face are only accelerating our ability to be more agile and flexible in this emerging operational environment. I'll give you an example and just let you know kind of the span of things that folks are doing.

Everybody's aware that the *Comfort* pulled into New York Harbor. Very inspiring. The intent initially was that they would offload hospitals so that those hospitals could focus on COVID. It ended up becoming a COVID intensive care center themselves. Really tremendous work on short notice to convert a combat casualty care facility to do that.

We also sent out medical teams taken from our Expeditionary Medical Facility to support local hospitals, and we learned a lot about how to make those teams very agile. In fact just like we have a small seven-person surgical team, based on that experience, we now have a small seven-person medical intensive care team. So now as Delta has increased the demand signal on our civilian hospitals, just yesterday one of our teams was assigned and arrived in Lafayette, Louisiana to help the local hospital there. That's a three person team, based

on lessons learned from those teams that have gone out earlier.

So while that -- all of our folks are enormously proud of the fact that they can help their fellow Americans, but the longer term implication for us is, we're learning valuable lessons about how to be more agile as we think about future deployments in that broad based distributed environment that we may find ourselves in. So I'm a huge fan of high reliability organizations understanding how to achieve high reliability, and I would say that process, the process of participating in COVID operations has only accelerated that journey for us. So as challenging as it is I think when it's all said and done Navy medicine is going to be stronger, we're going to be able to project that medical power even more powerfully in support of our warfighters.

MODERATOR: Once again, sir, thank you for your time and for sharing your wisdom and knowledge with us. I thanks to you and your staff for all that you do. And we hope to have you back in the near future, sir.

RADM GILLINGHAM: Thank you, Thom. I really appreciated the opportunity. And thanks to all who participated today.

END OF RECORDING

THE FORCE AT 50:

A RETROSPECTIVE OF THE FORCE MASTER CHIEF OF NAVY MEDICINE

By André B. Sobocinski, Historian, BUMED

"I knew how important it was, I just didn't know how truly important it is," said FORCM Michael J. Roberts on being the Force Master Chief of the Bureau of Medicine and Surgery (BUMED).

Roberts assumed this title—and with it—the helm of the Hospital Corps in October 2020 after a career that included tours as Command Master Chief of 1st Marine Division, 2D Marine Logistics Group, 2D Medical Battalion and deployments aboard USS *Nitze* (DDG-94), USS *Kearsarge* (LHD-3). To date, he is only the sixteenth individual to serve as Force Master Chief of BUMED, a position that marks its fiftieth anniversary in 2021.

Since 1971, Force Master Chiefs of BUMED have served as senior enlisted advisors for Navy Surgeons General, and the voice for some 26,000 active and reserve Hospital Corpsmen in the Navy on matters relating to the welfare, health, job satisfaction, retention, morale, utilization, and training.

Although it is easy to acknowledge the necessity of the role, the Hospital Corps was already 72 years old when the position of the "Force" was established. On July 20, 1971, the Force Master Chief of BUMED (originally "Master Chief Petty Officer of BUMED") was one of 23 senior enlisted positions created by Adm. Elmo Zumwalt, the Chief of Naval Operations. The purpose was to ensure that the Navy's enlisted communities had representation on the vital issues affecting the entire service.

THE FIRST FORCES 1971-1991.

In July 1971, Master Chief Robert Swartout, then serving as head of the enlisted training program at BUMED, was selected by Surgeon General Vice Adm. George Davis as the first Force. The tradition of Surgeons General selecting the Force has continued to this day.

The First Forces came up through the ranks in the 1940s, 1950s, 1960s and 1970s. These were individuals whose careers and outlooks were shaped by World War II, Korea and Vietnam, the uncertainties stoked by the Cold War and the ongoing morale issues of the 1970s. In the first 20 years of the Force, six individuals served at the helm of the Hospital Corps.

- Master Chief Robert Swartout was a veteran of the hard fought Guadalcanal campaign and later served at first forward deployed hospitals in the Pacific War. In the 1950s, Swartout was assigned to Joint Task Force 132 which oversaw Operation Ivy, the first successful full-scale test of a hydrogen bomb. He reported to BUMED in 1963 after a tour as Command Master Chief of Naval Hospital Yokosuka. After two years as Master Chief Petty Officer of BUMED he retired in 1973.
- Master Chief Horace Anderson's service included tours in Korea and Vietnam. Anderson was selected as Master Chief Petty Officer of BUMED after serving as the Senior Enlisted Advisor at the Naval Medical Regional Clinic in Washington, D.C. He served at the head of the Hospital Corps from 1973 to 1977.
- Master Chief Harry Olszak was a former blood and laboratory technician who had served aboard the hospital ship USS Haven (AH-12) after the Korean War, at the Naval Medical Research Unit (NAMRU) No. 4 in Great Lakes, and Preventive Medicine Unit (NEPMU)-6 in Pearl Harbor, H.I.. He became head of the Hospital Corps in 1977 after a tour as Command Master Chief of Naval Regional Medical Center Portsmouth, VA. He retired in 1979.
- Master Chief Stephen Brown was the first senior enlisted leader at BUMED to use the "Force Master Chief" title. Brown began his career assigned to the 1st Marine Division in the Korean War. He reported to BUMED in 1979 after serving as the Command Master Chief for Naval Regional Medical Center San Diego, Calif. As the top "doc" in the Hospital Corps, Brown was known as an innovative and resourceful manager, advocated for improvements in military enlisted family housing and unaccompanied enlisted personnel housing and helped initiate a proposal

for a Navy Enlisted Nursing Education Program later to develop into a Medical Enlisted Commissioning Program. In 1983, Brown helped introduce the concept of the "Medal of Honor" wall for Navy medical facilities to honor the service of the Corpsmen who earned this distinction. He served as Force Master Chief from 1979 to 1983.

- Master Chief Louis Green's career included tours with the 3rd Marine Division in Chu Lai, Vietnam, aboard the USS DeLong (DE-684), Command Master Chief of the Naval Submarine Medical Center, Groton, Conn., and the Naval Health Sciences Education and Training Command, Bethesda, MD when he was selected to be the Force Master Chief. He served in this role from 1983 to 1987.
- Master Chief William (Bill) Griffith's career include tours in Vietnam, and service aboard USS California (CGN-36), and USS Nimitz (CVN-68). He served as Command Master Chief of Naval Hospital, Portsmouth, Va., Naval School of Health Sciences, Bethesda, Md., and the National Capital Region, Bethesda, Md. prior to his selection as the Force Master Chief. He retired in 1991 after overseeing the Hospital Corps during the Persian Gulf War.

THE SUBMARINERS– THE FIRST WARFARE-DESIGNATED FORCEs

HMCM Charley Williams was selected as the new Force Master Chief of BUMED in 1991 succeeding Master Chief Bill Griffith. Williams entered the service during the Vietnam War and spent 15 years aboard submarines. Prior to coming to BUMED, Williams was the Command Master Chief for the Submarine Forces Atlantic (SUBLANT) and had worked closely with the SUBLANT Force Master Chief. When he took the helm, Williams—a submarine warfare specialist—became the first Force with a warfare designation. Spending most of his career on the operational side, he admits that he did not know Navy Medicine had its own Force. "It was kind of a shock to me to find

out you were in charge of all of the Corpsmen and Dental Techs," said Williams.

In the early 1990s, the military was facing significant cutbacks and entering a period of downsizing. His first job as Force Master Chief was sitting on the first ever Selective Early Retirement Board from a closed locker room at the old Arlington Annex. "We went through all the records and we chose some very good people to go home because we had to get the military downsized to meet the President's goal," recalled Williams.

Williams was succeeded by another submariner and Vietnam veteran in 1994, Master Chief Mike Stewart. Prior to his tenure as Force, Stewart spent years as an Independent Duty Corpsman aboard submarines USS *Nathan Hale* (SSBN-623), USS *Nautilus* (SSN-571) and USS *Casimir Pulaski* (SSBN 633). He later served as Command Master Chief of the Naval Medical Command, Northwest Region, Naval Hospital Oakland, Calif.; and the National Naval Medical Center, Bethesda, Md. As Force, his chief goal was to bring the Navy's deck-plate values back to the Hospital Corps and help ensure operational readiness. "Bringing back our deck-plate values allowed our Corpsmen to get out of the administrative realm and back into patient care in preparation for deployments for any crisis that would come up around the world," said Stewart.

THE DIRECTOR OF THE HOSPITAL CORPS

"Whenever I go on my travels I have two jobs," said FORCM Roberts. "I am the BUMED Force Master Chief and I am the Director of the Hospital Corps."

The head of the Hospital Corps did not always serve in this double-hatted role though. For the first eight years of the Force Master Chief, the Director of the Hospital Corps was a position held solely by commissioned officers, typically 0-6 Navy nurses and Medical Service Corps officers. In June 1979, Vice Adm. Willard Arentzen granted Master Chief Stephen Brown the role of Director during his tenure, but this position was short-lived for the Navy's top enlisted "doc." Despite the fact that the Force served as the most senior enlisted leader in Navy Medicine and was advisor to the Surgeon General on issues related to Hospital Corpsmen, their decision making before and after Brown was limited.

"I had a very close relationship with the nurse who was serving as the Director of the Hospital Corps, but I didn't have a lot of input when they made decisions and did what they thought best for the Corps," remembered Master Chief Williams. During his tenure as Force, Williams and his team worked to show the Surgeon General that the Hospital Corps was "capable of taking care of their own" and Vice Adm. Donald Hagen agreed. When Master Chief Stewart succeeded Williams in 1994 he assumed the title as the Director of the Hospital Corps. And since 1994 every Force has also served as the Hospital Corps Director.

The duties as Force and Director of the Hospital Corps are in some respects intertwined. "The roles we play depends on what audience we are talking to at the time," related FORCM Hosea Smith, who served as Force Master Chief and Director from the Hospital Corps from 2017 to 2020. "You can look at these titles on the same playing field because when I spoke with someone outside of Navy Medicine they knew me as the Force Master Chief, but being Director was job number one."

For Stewart—as the first enlisted leader to hold both titles after 1983 there was some overlap, but the roles had important distinctions. "As Force Master Chief you are dealing with issues about morale and welfare of all the sailors in Navy Medicine," said Stewart. "But as Director of the Hospital Corps you are dealing with education and training, the schools, the enlisted community manager, the detailers, and the manpower folks."

THE TRAVELING FORCE

Any Force can tell you that one constant for the job is travel. The Force is there for each Hospital Corps graduation, and is always by the Surgeon General of the Navy's side as they travel around the world visiting Navy, Navy medical and Marine Corps activities and commands. And for many Forces, the ability to get out and be connected to their sailors in the field is often the highlight of their tenures.

"I did an awful lot of travel," recalled Master Chief Stewart. "I was gone probably 65% of the time, but I got to meet all these sailors everywhere we went and to see the incredible things they were doing. I visited so many ships, submarines, Marine Corps units all around the world, and it made you realize what an incredible team the Navy and Marine Corps is and how we work so close together. It's

unbelievable."

Sometimes these trips can be more harrowing than one would like. In the early 1990s, Master Chief Charley Williams joined Surgeon General Vice Adm. Donald Hagen and his aide Lt. Cmdr. (later Capt.) Kelly McConville on a trip across the Pacific. While traveling on an S-3 from Okinawa to mainland Japan their plane encountered a serious technical malfunction. "As we were climbing out we heard a loud boom," remembered Williams. "I'm looking up at the cockpit and the co-pilot is going through the emergency procedure book, and then they announced, 'We just had a flame-out on the starboard engine, so we're dumping fuel and we're going to swing around and make an arrest wire landing back at Kadena Air Force Base.' I guess the most frightening thing in the world was when we stopped. I'd never stopped like that on an airplane. But when we did stop, I looked out the window and there must have been 40 little silver suits running around with fire trucks. They knew where you were going to stop and they were waiting for us. And you're thinking, 'Oh gosh, are we going to burn up here?' And all they did was tow us back over to the hangar, pulled out another one, put us on that and then we took off again. But that was an interesting trip. You could see the co-pilot. He was tapping on the dash. And my thought process at the time was, he's thinking, 'For Heaven's sake, let's get this thing on the ground. I don't want to be responsible for losing the Surgeon General of the Navy.'"

Of course, a key for any trip is having the right team back at headquarters. Forces interviewed for this retrospective each mentioned the importance of having a good team and deputy to run the office when they are traveling. "As the Force Master Chief you're a traveler— everybody wants the opportunity to meet you whether it's at a hospital, clinic, a ship visit or on a Marine Corps installation," said Master Chief Laura Martinez who served as Force and Director of the Hospital Corps from 2007 to 2011. "As you are traveling your deputy plays an essential role in the day-to-day operations while the Force is out meeting sailors."

THE SURFACE SAILOR, FMF DESIGNATORS, AND THE MARINE PIN

The Force Master Chief serves as the head of the entire Hospital Corps—and 40 Navy Enlisted Codes (NECs) in total—from the quad-zero (general duty) Corpsmen to Fleet Marine Force (FMF) Corpsmen ("8404s"). This was something HMCM Mark Weldon was aware of when he became Force Master Chief and Hospital Corps Director in 1998. Like all Forces since Master Chief Charley Williams, Weldon had been operationally-focused and had come from the line side. He had served as Command Master Chief aboard USS *Whidbey Island* (LDS-41), at Naval Station Mayport, Florida and was the first surface warfare-designated Force. Recognizing that a "shore-duty mentality" still pervaded the Hospital Corps, he espoused three priorities when meeting his Corpsmen. "I sought to enhance operational capabilities," said Weldon. "My other priorities were to train to those requirements and develop tomorrow's leaders today." And for those doing the job as warfighter he wanted them to get the recognition. As he looks back, Weldon notes one of his proudest accomplishments was getting the FMF badge or pin approved for his "greenside" Corpsmen.

"The Hospital Corps is the most diverse rating in the Navy, and we're in every community from Special Forces down to Air Surface, subs, divers—we're everywhere," said Weldon. "A lot of them had done or would do an FMF tour no matter what community they ended up in. The FMF pin had been talked about for years and it seemed like an issue that people could rally behind and that's why I pushed that. And I did that working with the other Fleet Force Master Chiefs, all of whom were supportive of it."

All Forces interviewed for thsi story have acknowledged the importance of having that connection with the greenside. To date, a total of six Forces—from Master Chiefs Robert Elliott in 2006 to Michael Roberts today—have worn the Fleet Marine Force warfare designator. Years before becoming a Force, Master Chief Sherman Boss was finishing up a tour at Naval Hospital Keflavik and in the Command Master Chief program when he received orders for Okinawa. The submarine and surface designated Independent Duty Corpsman (IDC) knew he needed field medical training in order to have a better understanding of what FMF Corpsmen go through. As a senior "9580," he got permission from Force Master Chief Jacqueline DiRosa to go through Field Medical Service School. "Here I was a 9580 Command Master Chief, 43-44 years old and all my classmates were 18-19-year old kids," said Boss. "I did every push-up, every pull-up, every calisthenic, every hump; I did everything because I knew that I represented

the senior enlisted of the Navy." Years later while serving as the Force Boss remembers young sailors coming up to him remarking that they went through Field Med with him and seeing him go through that training had inspired them.

FORCE FIRSTS

In 2002, Master Chief Jacqueline DiRosa was selected by Vice Adm. Michael Cowan as the tenth Force Master Chief of BUMED. Like Master Chief Weldon, DiRosa had spent the greater part of her career in the surface Navy. And she had served as the Command Master Chief of USS *Blue Ridge* prior to her selection. When she took the helm in April 2002, DiRosa earned the distinction as not only the first woman Force of BUMED, but also the first woman Force Master Chief in the entire U.S. Navy. "I remember getting the call from Admiral Cowan and sitting the phone down. I was overcome with emotion because as a Hospital Corpsman I saw being Force as the pinnacle of my career, my opportunity to truly make a difference and to have a voice for change," said DiRosa.

Looking back on her first years in the Navy, FORCM DiRosa recalled an encounter with her Lead Petty Officer (LPO) at Naval Hospital San Diego.

"I was one of these people who always saw things like 'why aren't we doing it this way?' And I always had questions, and was always exploring ways for making things better; that's just the way I was wired," said DiRosa. "One day as a very junior sailor my LPO said to me, 'If you want to make a difference you can make a change, but you need to be in a position where you can.'"

As she came up through the ranks there were not many examples of women serving in senior enlisted positions. "I can remember back in '81-'82 I saw my first female master chief and I stood in awe," stated DiRosa.

"And it's interesting, throughout my career, particularly as Force, I was still hearing, 'You're the first female master chief I've ever seen.'" At that point the Navy was still undergoing cultural changes and as DiRosa admits culture can sometimes change very slowly.

With any distinction comes greater visibility. And for FORCM DiRosa, she knew that she had to be an active voice and advocate for her sailors and needed to be highly involved because as she put it: "You've got to be the champion and fight to help continue to keep the changes progressing."

In November 2007, Navy history was again made when Vice Admiral Adam Robinson selected Master Chief Laura Martinez as the new Force Master Chief of BUMED. She was only the second woman to serve as the Force and was the first African-American selected for this role. An FMF-designated specialist, FORCM Martinez had served as Command Master Chief at Naval Hospital Okinawa, with 2d Marine Logistics Group, Camp Lejeune, N.C., the National Naval Medical Center, Bethesda, Md., and Field Medical Training Battalion-East. (FMTB-East) prior to her selection. "I was truly honored by the selection to serve as the twelfth Force Master Chief," said Martinez. "Being the first women of color and the second woman to hold this position, I hope I set the path for those who will come behind me."

NEW OPPORTUNITIES FOR DENTAL TECHNICIANS

Throughout much of their history Dental Technicians were a part of, but still separate, from the Hospital Corps. In the 1920s, the first Hospital Corpsmen graduated Navy dental courses for enlisted personnel becoming, in essence, proto-Dental Technicians. And in 1948 the Navy authorized the Dental Technician (DT) rating. The DT rating insignia even appeared on the Navy Medical Department flag from the late 1940s through the 2000s alongside symbols of the four staff officer corps and Hospital Corps. Despite their separate status from the Hospital Corps, all DTs historically came under the realm of the BUMED Force Master Chief.

Over the years, many Navy medical leaders recognized that DTs did not have the same opportunities as Corpsmen for promotion and their assignments were usually limited to dental activities. During Master Chief Stewart's tenure efforts were made to open up the Command Master Chief billets across Navy Medicine so that Dental Techs could serve in roles typically occupied by Hospital Corpsmen and vice-versa. And by Master Chief Weldon's time as Force Navy Medicine began exploring merging DTs into the Hospital Corps rating.

"As the Force I started visiting dental clinics and those Dental Techs were always sharp and had attention to detail," remembered Weldon. "At the same time, all the DTs

that I spoke with said, 'We just can't make rank.'" Recognizing that DTs should have the same opportunities for advancement and seeing an underutilization of available assets Master Chief Weldon and his team started pressing for reorganization. When FORCM DiRosa succeeded Weldon, the DT-HM merger became a chief issue and one of great heartache for some.

"I had a few Dental Tech master chiefs that were not in favor of it," said DiRosa. "And I had a few of them on my working groups to get them involved, to hear their voices and their arguments on why they were concerned. Also, I wanted them to hear the other side of the argument and be able to critically analyze the big picture and eventually become supportive."

On October 1, 2005, some 3,000 DTs serving "chairside" and administratively at dental and medical activities worldwide became part of the Hospital Corps. Among those "new" Corpsmen was Master Chief Terry Prince who in 2017 was selected as Force Master Chief, the first ever DT to serve in this role. "That was an incredible opportunity," said Prince about the DT-HM merger. "I know there was a lot of heartache amongst the Dental Techs at the time, but those of us who were a little bit smarter about life understood that this was going to open up entirely new opportunities for us."

Prior to becoming Force, Prince had served five operational tours of duty with the First, Second and Third Dental Battalions and the Third Force Service Support Group in Okinawa, Japan. He later also served in senior enlisted positions at Naval Hospital Camp Lejeune, N.C., Navy Medicine National Capital Area/Walter Reed National Military Medical Center, Bethesda, Md., and the Defense Health Agency. Coming up through the ranks FORCM Prince recognized that DTs were no different than HMs and both were healthcare professionals. "The reality is that dental techs weren't able to go to their CO; they weren't able to go to a lot of ship billets, and this opened up all kinds of opportunities," said Prince. "And on a personal level, it ultimately helped me become Master Chief and do the things that I was able to do."

HOSPITAL CORPS SCHOOL CLOSURE AND RELOCATION

Improving how Corpsmen are trained and ensuring that they are imbued with the skills and knowledge for current and future challenges has been a constant over the history of the Hospital Corps. It has also been among the greatest challenges for Force Master Chiefs. Factors of BRAC, financial cutbacks, divestitures and remaining operationally ready while preserving the Hospital Corps' cultural identity have only made the decision-making process more complicated over the years. And these decisions are never without some controversy, especially when culture and heritage are at risk. An example of these difficult decisions can be seen with the disestablishment of Hospital Corps School San Diego in 1997.

As far back as 1928, a Basic Hospital Corps School had existed at Balboa Park in San Diego. And from the late 1940s until 1997, Corpsmen attended either the "basic school" in San Diego or Great Lakes. During Master Chief Stewart's tenure as Force the decision was made to close the San Diego site. "Closing the school offered better opportunities for patient care, and better opportunities for Corpsmen to grow," related Stewart who made this difficult decision. "I remember at that time we implemented guidelines so that if a Corpsman didn't pass a physical fitness test, they couldn't graduate from 'A' School. And it was very difficult to do physical fitness out in Balboa Park where the school was located. Merging those two schools together, brought all of our talent and energy into one spot and everybody was trained exactly the same way."

Fourteen years later a decision was made to relocate the Navy's remaining school in Great Lakes to Fort Sam Houston, San Antonio, Texas. FORCM Laura Martinez was at the helm as preparations were made for this historic relocation that was driven both by cost savings and they need to meet goals of "jointness" between the services. "We were closing three major school houses at the time," recalled Martinez. "We were closing the Naval School of Health Sciences detachments at San Diego and Portsmouth and we were closing Great Lakes, which was a huge concern because we didn't want to lose our service identity. That was very, very heavy on my plate during that time."

Being the Force often requires walking a tight rope. The relocation of Corps School and finding common ground with the other services was to remain an issue for years after the move and involve many growing pains. Master Chief Sherman Boss who succeeded Martinez in Octo-

ber 2011 related that these experiences made the services gradually realize that Hospital Corpsmen and Air Force and Army Medics were very different. "We have such a different mission that there were areas that we could be very successful in a collaboration and joint, if you will, in the training environment, but you can't put a round peg in a square hole," related Boss. "Just as San Antonio was opening its doors the Army pulled out and said, 'Don't need to do it' And then it was an Air Force/Navy school, and initially it worked okay, but not great. The way the training requirements for the other services were much different than the training requirements for the Navy. Instructors had to have certain credentials that the other services required but the Navy didn't. Army wanted all of their medics to be EMTs, but we recognized that every Hospital Corpsman doesn't need to be an EMT. Some do, but not all of them do. Getting the Army to understand the reasoning behind that, and that you can't create one healthcare provider across the three services that could operate in whatever environment they want was really hard."

The year 2021 marks the tenth anniversary of the historic move to San Antonio. Master Chief Martinez, now the Quota and Corporate Enterprise Training Activity Resource System Manager at the Naval Medical Forces Support Command in San Antonio has a unique view of the relocation. "We were able to make that course correction for our Basic Hospital Corpsman, and so now Air Force trains Air Force; Army trains Army; Navy trains Navy," said Martinez. "And to see that evolution from the very beginning, and ten years later to see us still producing those people who everyday are contributing survivability to lethality, is pretty cool."

SHARED SERVICES, NEW INITIATIVES AND INNOVATIONS

Prior to being selected as Force Master Chief by Vice Adm. Matthew Nathan in 2011, Master Chief Boss had served with the future Surgeon General at Naval Medical Center Portsmouth and later at the National Naval Medical Center. Along with Admiral Nathan, Boss was front and center for the historic merger of the National Naval Medical Center and the Walter Reed Military Medical Center. "It was, as Admiral Nathan used to say, 'Like rebuilding an airplane while in flight,'" said Boss. "And that's essentially what we were doing. Not only do we have the amalgamation of Army and Navy and Air Force, but we were still receiving casualties on Wednesdays and Fridays and the medical center was under constant construction—it was chaos."

As Force Master Chief, Boss still periodically made trips to Bethesda where on one occasion he met an EOD sailor and double amputee who was receiving treatment there. "I got to know the family well while he was at Bethesda," recalled FORCM Boss. "And on one occasion I joined he and his family as we left the building. His wife was pushing him in a wheelchair, with two kids on each end, and he looked at me as he was getting ready to get into the car and said, 'Doc, I'm going to be okay.'

"And I thought then and there, 'That's why we do what we do.' And that's what every Corpsman should remember throughout their careers—their job is going to be 95% boredom interrupted by 5% chaos. And as long as they have the training and the equipment and the care to know what to do during that 5% of time then whoever they're helping is going to be okay."

During his tenure as Force, Boss helped navigate the uncharted waters of jointness and shared services. With this came a need to bridge the gap with the other services and educate them about the uniqueness of the Hospital Corps. "The Army couldn't understand how a Hospital Corpsman who wasn't a LPN [Licensed Practical Nurse] could serve on a ward or how Independent Duty Corpsmen (IDCs) operated independently," said Boss. Working with his counterpart in the Army, Boss arranged to have two Army medics go through the Navy IDC School. And to introduce the Army mentality to the Navy, Boss selected 10 Corpsmen from Bethesda to go through Army LPN School in San Antonio. As Boss related, "This drove my agenda. I wanted to make clear that the services had the same roles, but there are different ways of getting there."

Ensuring that Corpsmen have the advanced skills to meet operational readiness goals Force Master Chiefs have often looked for ways of making the training experience more relevant. This was a guiding light for Force Master Chief Hosea Smith during his tenure in office. Master Chief Smith took the helm of the Hospital Corps in March 2017 following Command Master Chief tours at Naval Hospital Okinawa, Navy Medicine West and Naval Medical Center

San Diego, Calif. As the Force, Smith oversaw the implementation of a new PQS, the growth of the Connected Corpsman in the Community program, the introduction of IDC formulary guidance, and the exploration of a new partnership with the Uniformed Services University of the Health Sciences (USUHS) for awarding undergraduate degrees to IDCs. But a chief goal was getting Corpsmen prepared for that next war. And a key part of this was the "trauma training" initiative.

"When I stepped into the role of Force, the Surgeon General [Vice. Adm. C. Forrest Faison] said 'We want to do trauma training for our Hospital Corpsmen,'" recalled FORCM Smith. "That threw us all for a loop and we had to think outside the box because we'd never done that." FORCM Smith and his team worked on developing the concept and set out to establish partnerships with trauma centers in order to give Corpsmen (E-5 and below) an opportunity for hands-on training. Leveraging an existing relationship with the John H. Stroger, Jr. Hospital of Cook County, Chicago, Illinois, Navy Medicine formalized a pilot program in 2018 for what is now called the Hospital Corpsman Trauma Training (HMTT).

Today, the Navy HMTT course is available at four sites—Stroger, the University of Florida Health (Shands) in Jacksonville, Fla., University Hospitals Cleveland Medical Center in Cleveland, Ohio and Wake Medical Center in Raleigh, N.C. Presently about 350 sailors go through the rigorous 7-week program each year.

SERVANT LEADERSHIP AND LEGACY

For Master Chief Mike Stewart, Force Master Chief is not a "position" but rather a "critical job" in Navy Medicine. "There's a difference between a job and a position," explained Stewart. "In a position you get the title and you get the picture on the wall, but the job is to get in there and work, wrestle and defend the rights of all those sailors that you represent. It's not just going to fancy balls and giving speeches. You've got to be willing to take the hard cases for sailors that are being unjustly treated or denied opportunities and be willing to go to bat for them. That's the whole reason why you're there as the Force Master Chief. It's not to get another stepping stone for you, it's to help everybody else move up and enjoy the Navy as much as you have."

In looking back at his time as head of the Hospital Corps, FORCM Terry Prince notes that it was important to him that the Corpsmen knew that their voices were being heard. "I wanted them to know how important it is to represent the Hospital Corps at the table with the Surgeon General," said Prince. "The Hospital Corps has a voice at the top level of Navy Medicine, and their concerns and their ideas and their dreams are being looked at every single day. And I wanted them to know that the Force and the entire Force staff is there for every one of those sailors in order to give them opportunities to achieve whatever successes they want to achieve."

The notion of service to the Hospital Corps resonates to this day with Force Master Chief Michael Roberts and drives his agenda in office. Whether in uniform or out of uniform, he states that being the Force Master Chief is a "24/7" job to ensure that his sailors' voices are being heard. "As Force Master Chiefs we serve them, they don't serve us," explained Roberts. "Every day you're going to say 'I serve people. I work for them,' but when you go home, can you say that you did a good job? Did you serve the people well? Did you give the appropriate answers or give them direction of where to go?"

In the end, the job of Force Master Chief has been personal for all 16 who have been selected for the role—all of whom came up the ranks as enlisted healthcare professionals and each ended their service careers in a role that allowed them to listen, connect and serve as their community's voice. "When I get up to talk to a bunch of sailors in the field I leave so full of energy, I'm excited for them," related Roberts. "I give them answers that they were not expecting or give them something that they knew was probably on the horizon and validate it. And for me that's probably most rewarding aspect of being the Force."

As we mark this fiftieth anniversary of the Force Master Chief—and look ahead at the future of Navy Medicine—that special bond is perhaps the greatest legacy of the Force Master Chief of BUMED. And for as long as there is a Corpsman serving as Force Master Chief you can guarantee that bond will not be broken. ●