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COVER: USNS *Comfort* (T-AH 20) gleams with a fresh coat of paint while in a Baltimore shipyard for routine maintenance. Story on page 15. Photo by HM1 Jim Moyer, NMETC.

Department Rounds

Sea bags were being packed as Sailors from Fleet Hospital 20 headed home after nearly a year of providing medical treatment to a very unique kind of patient, suspected Taliban and Al Qaeda detainees.

Based primarily out of Camp Lejeune, NC, and several other naval hospitals, their tour of duty was over but the mission here remains in full swing. In January 2002, this remote, almost serene duty station was tasked with building a detention facility to house captured combatants from Afghanistan. A Joint Task Force was quickly put together to handle this massive effort. The end result was the now infamous "Camp X-Ray."

Almost immediately, the nation watched the progress as loads of media from national and international agencies flew here to report on a story that was destined for the history books.

As the operation grew, so did the scenery on the edge of the Caribbean waters. Working in the hot Cuban sun, Fleet Hospital 20 Sailors rolled their sleeves up and, with the help of Navy Seabees, cleared a stretch of sage-laden land and set up a series of connecting tents that would serve as their field hospital. The tents were then filled with all the necessary hospital gadgetry needed to handle any medical situation that could arise.

Just 8 days after the start of the setup, the first detainee arrived for treatment and began receiving the same quality treatment that service members and their families receive throughout the world.

Media attention immediately turned to the Fleet Hospital. Twice a week they came to be briefed and to see first hand how the detainees fared under the skillful hands of the medical team. High ranking military officials and members of Congress fol-

Fleet Hospital Sailors Say Goodbye to Gitmo

lowed suit and the end result of the positive exposure changed world perception.

As months of day and night shifts took care of patients inside the tents, the field just beyond the barbed wire compound was changing fast. Construction was underway for a new detention facility and hospital that would eventually replace "Camp X-Ray" as well as Fleet Hospital 20's tattering tents.

The new detention hospital lies within the same barbed wire compound and is an impressive permanent structure that looks like any other hospital you might visit, minus the watchful eyes of Army guards that are always present when a detainee is being treated or admitted.

Since December 2002, reliefs have been arriving to replace members of Fleet Hospital 20, fresh faces energized and ready for the task at hand. "I've been here for 2 days and I love it," said a smiling HN Robert Harper, who flew here for a 6-month hitch from Bethesda, MD. Harper has been working on the ward where some of his duties include administering medication to the detainee patients.

The mood of the departing group was upbeat. Many expressed pride in being able to play such vital roles in this historical event, Sailors like HM3 Monica Vanderlois, who headed back to Camp Lejeune. "I think it's really neat that there are a lot of other young

people coming here that just came in the Navy and can come here and do this," said the Callahan, FL, native. "I just feel very proud," she added.

"As I watched the staff of the Fleet Hospital transferring out, and the amazing job that they did, and the actual transition of them teaching the new corpsmen that are arriving on this corpsman driven mission, its truly an amazing thing. The attention to detail and the eagerness is amazing," said HMC Marvin Kitchens, who serves as hospital's senior enlisted advisor. "It's a personal drive for them to come here and do a phenomenal job and to do the right thing for something that has never been done before in Navy medicine," Kitchens added.

One of the new faces on the block has been here before. LT Cambrai Reed, an original member of the Fleet Hospital team, volunteered to come back for a second tour. The changes she discovered that took place while she was away took her by surprise.

During Reed's group tour of the new compound, her eyes reflected the surprise of so many changes. Gone were the hospital tents that demanded so much of her attention during her last stay. "I can't believe how different everything looks," said Reed, as she walked through the shiny new hospital. Her previous wisdom no doubt will come in handy to the shipmates that arrived with her. "I was happy to come back and share some

insight to those who haven't experienced this kind of unique environment. This is cutting edge," she added with a smile.

The Fleet Hospital 20 Sailor with the most time under her belt just happens to be the current Officer-In-Charge, CDR Jaime Carroll. She has been here since the land for the entire compound was cleared and soon

packed her bags as well. She said she is proud of her shipmates and was more than happy to testify on their behalf.

"The credit and success of this mission here with Fleet Hospital 20 goes to all the people who have been here since the very beginning," said Carroll—"Our CO, CAPT Pat Alford, and every single individual who was

out here working as a team, and being committed to this mission."

And so as this medical team packed up their belongings and prepared to fly home, they stood "properly relieved" from their very close connection to "Operation Enduring Freedom." □

—Story by JOC Austin, Public Affairs Officer, Health Support Office, Jacksonville, FL.

* * *

The German Federal Navy Medical Observership at

NEHC

CDR (MC) Alex Rump, Federal German Navy

CAPT (MC) Klaus Seidenstuecker, Deputy Surgeon General of the German Navy

The Federal German Navy (FGN) has long maintained a medical observership program at U.S. medical institutions based on the Foreign Military Sales Program (FMS). The program initially included 1-year observership in clinical medicine at the National Naval Medical Center in Bethesda, MD. With the focus in military medicine shifting from pure combat surgery to a more comprehensive approach, the German Navy moved that program toward expanding expertise in the preventive medicine fields.

In 1989, the Surgeon General of the German Navy, ADM Dr. Proehl, established a training program with emphasis on occupational and preventive medicine. The head of the first Directorate at the German Naval Medical Institute, at the time CAPT Dr. Seidenstuecker, was tasked to determine which medical institution in the U.S. Navy best met the needs of the German Navy. Following visits by

Dr. Seiderstuecker to several Navy medical and research facilities, an agreement was established in 1990 between the Bureau of Medicine and Surgery and the Health Service of the German Navy. That agreement established a 6-month observership program at the Navy Environmental Health Center (NEHC) in Portsmouth, VA. This institution seemed particularly suited to meet the needs of the German Navy because of its broad range of preventive medicine activities, including occupational medicine, industrial hygiene, clinical epidemiology, and medical surveillance, as well as advanced approaches in health promotion. NEHC was perceived as having both research expertise as well as long standing experience with the practical issues of maritime medicine and modern naval warfare. The basic idea was to integrate the German medical observer into the activities of the Directorate of Preventive Medicine at NEHC where he

would gain experience by "hands on" training.

The first German observer was assigned to NEHC in 1991 and the program has operated continuously since, proof of its success. From 1991 to 2002, 20 German Navy medical officers have completed the observership program, most of them being physicians, but also including two pharmacists and one dentist. The physicians participating in the program have come from variable backgrounds, including general practitioners, toxicologists, hygienists, and even anesthesiologists. Over time, the German medical officers have expanded the training schedule to allow more flexibility to meet their needs based on prior specialization and planned future assignments. The German medical observers attended a variety of training courses offered by other U.S. Navy institutions, or even other services. Nevertheless, the emphasis of the observership program re-

mains on occupational and preventive medicine, as initially conceived at the time of its establishment.

With the recent reconfiguration of the German Armed Forces, personnel availability in the Health Service of the Navy has become limited. The assignment of health professionals from the Federal German Navy to the Joint Health Service, and vice-versa, is common practice. Although the loss of qualified personnel stretches our service resources, the Medical Observership in Occupational and Preventive Medicine remains an important investment for the Navy. Those physicians who have completed the NEHC observership program are a great asset for the Health Service of the German Armed Forces as a whole. □

OSA (MC) Alexis Rump served as the German Navy Medical Observer to NEHC at Norfolk, VA in 2002.

CAPT (MC) Klaus Seidenstuecker is the Deputy Surgeon General of the German Navy.

Examples of training courses of interest for German medical observers
Clinical Epidemiology Training Course (NEHC, Portsmouth)
Population Health and Healthcare Epidemiology Training Course (NEHC, Portsmouth)
Health Promotion Director Training & Certification Course (NEHC, Portsmouth)
Navy Environmental Health Officer Orientation Course (NEHC, Portsmouth)
Medical Management of Biological and Chemical Casualties Course, MCBC (USAMRIID and USAMRICD, Aberdeen Proving Grounds)
Joint Planning Orientation Course, JPOC
Joint Medical Planning Course, JMPC (NNMC, Bethesda)
Combined Humanitarian Assistance Response Training, CHART
Workshop (NEHC, San Diego, and Chesapeake)

NEHC CO Recognized by Federal German Navy

CAPT Bruce K. Bohnker, MC, USN

CAPT David M. Sack, MC, USN, the Commanding Officer of the Navy Environmental Health Center (NEHC), Norfolk, VA, was recently recognized by the Federal German Government. He was presented the Silver Cross of Honor of the Federal Armed Forces for his leadership and support for the Federal German Navy Medical Officer Exchange program. The award was made by RADM Uwe Kahre, Federal German Navy, who is the senior German Navy officer assigned to the staff of Supreme Allied Commander, Atlantic (SACLANT), Norfolk, VA. He serves at the Assistant Chief of Staff for Communications and Information Systems. RADM Kahre noted the uniqueness of recognizing non-German military personnel with the award and that the award was made on behalf of the Federal German government. CAPT Sack was recognized for his personal involvement in the military medical officer observership program that has been in existence for 10 years, and provided 20 German Navy senior medical officers with extensive training and diverse experiences during a 6-month assignment to NEHC. The flexible training program has been tailored to the interests and expertise of the visiting German Navy medical officers and has emphasized operational and preventive medical areas used to protect the Sailors and Marines in both the U.S. and Federal German military.

The award was presented at a ceremony that coincided with the departure of Federal German Navy Commander (MC) Soenke Jessen, who returned to



Photo courtesy of author

The ceremony where CAPT David M. Sack, MC, USN, received the Silver Cross of Honor of the German Federal Armed Forces. (Left to Right: CAPT Sack, RADM Kahre FGN, RADM Hart, CDR Jessen FGN)

Germany after completing extensive medical related training in Norfolk, VA, Washington DC, and San Antonio, TX. NEHC is Navy medicine's premier facility for occupational health and preventive medicine, and supports 10 subordinate commands throughout the globe that enhance readiness of the Navy and Marine Corps through leadership in prevention of disease and the promotion of health. □

CAPT Bohnker is Director, Population Health, Navy Environmental Health Center, Portsmouth, VA.

Laura Cobb A Kansas Nurse In a Japanese Prisoner of War Camp

Judith Johnson, Ph.D.

Conclusion



Photos from BUMED Archives

7th Fleet and Southwest Pacific Commander VADM Thomas Kinkaid welcomes liberated nurses to his Philippines headquarters. They are still wearing the custom made denim uniforms worn the day of their rescue.

In the early morning of 14 May 1943, 11 Navy nurses, three civilian nurses, and almost 800 male internees began the trek in railroad box cars to Los Baños. The trip took over 7 hours to cover about 70 kilometers. Los Baños, located south-east of Manila at the lower end of Laguna de Bay, had been an agricul-

tural college in the heart of coconut and banana plantations. At an altitude of 2,000 feet, the area had a more comfortable climate and less incidence of malaria than Santo Tomás. Despite the pleasant surroundings, Los Baños turned out to be less accommodating for the nurses than their previous camp. The internees arrived

hot, dirty, hungry, and very thirsty. When they left Santo Tomás, they had each been given a hard-boiled duck egg and a piece of bread; that was their only food for the day. Yet their main concern was water. While waiting for the male internees to find and then boil some water, the nurses were forced to sit on the grass and pretend,



Later that day, Laura Cobb and her flock sit down with VADM Kinkaid and his staff for their first real dinner in 37 months.

with empty cups, they were having a tea party. Japanese photographers then took their pictures, presumably for propaganda purposes.(28)

The first few days at Los Baños were hectic. Food was scarce and there was no water for bathing available. The camp covered approximately 50 acres and already had in place classroom buildings, dormitories, and small cottages. The Japanese took the nicest buildings for themselves. Cobb and her comrades stayed in barracks that had grass sides and roofs, but no floors. The buildings lacked screens and when it rained the roofs leaked. While definitely less congested than Santo Tomás, the quarters at Los Baños had been constructed in stables that horses and other animals had previously occupied. Consequently, large flies, maggots, and other insects created additional problems and were a constant annoyance. According to Cobb, the

Japanese allowed the nurses to bring only a few medical supplies with them from Santo Tomás. There was a small hospital within the compound, but the Japanese removed all the equipment before they allowed the Americans to use the building. Nevertheless, the nurses fashioned a 21-bed infirmary using cots and tables the other internees made. Broken pieces of corrugated tin roofing supplied material for cups and eating utensils. For medicine, Cobb later reported, they brewed leaves of plants and trees. The sap of a rubber tree served as an adhesive. When the Japanese insisted that the nurses treat their guards and soldiers, Cobb negotiated a trade of suture materials and some medicines in return.(29)

Once the nurses had established the hospital and additional barracks were built, the Japanese transferred more of the civilian prisoners from Santo Tomás and other camps near Manila

to Los Baños. A large contingent of mothers with young children also joined the growing population at the new facility during the summer months. With them came a round of common childhood contagious diseases such as measles, chicken pox, and even diphtheria. While these could be troublesome under normal conditions, they were deadly in the camp because of the potential for serious side effects and the lack of a proper diet for the children.(30)

On 15 November 1943, a typhoon hit the Philippine Islands including Manila and the prison camps in the area. Los Baños suffered extensive damage. The storm lasted for 3 days and left in its wake mud, downed trees, and destroyed barracks. By that time, the effects of prolonged malnutrition took a toll on all the internees who had to make repairs as best they could with limited resources and little energy. Nevertheless, Cobb and her subordinates worked continuously, treating the injured and the sick.(31)

While still recovering from the effects of the typhoon, the prisoners heard via the camp rumor mill that a ship carrying food and supplies was about to land in Manila. The *Gripsholm*, which was a Swedish vessel working with the U.S. government to repatriate foreign nationals and exchange prisoners, finally docked at Manila in late November 1943 with medicines and Red Cross packages of food and clothing for the internees. There was also an exchange of prisoners-of-war, but none were from Cobb's group of nurses. Although the Japanese rifled through the packages, taking what they wanted and destroying much of the contents, some of the medical supplies and food eventually reached Los Baños in January

Correspondents interview LCDR Cobb and her fellow nurses at Guam.

1944.(32) Cobb later reported that what little arrived was sorely needed because by that time all residents of the camp suffered from malnutrition. In particular, beriberi, a result of the lack of thiamine and other B vitamins, plagued all the prisoners.(33) Eventually, the camp population reached over 3,000 internees. The nurses were busy treating as many as 200 patients a day for various illnesses exacerbated by poor nutrition and deplorable sanitary conditions.(34) Dysentery was a major problem and limited intake of vitamins delayed the healing of even the smallest cuts and wounds. Many internees suffered from tuberculosis as well. Although they received small meals in the morning, at noon, and in the early evening, the diminishing quantity of lugao, mango leaves, and camotes, a native sweet potato, never met the nutritional or caloric requirements of either the adults or the children. Fat in the diet was non-existent.(35)

In the summer of 1943, as more and more internees arrived, Cobb and her colleagues worked 12 hours a day because there was so much illness in the camp. Then an epidemic of bacillary dysentery caused even more sickness and, as Cobb reported later, the entire camp became a hospital requiring the nurses to work longer hours. It was not unusual, she remembered, to see them faint from exhaustion and malnutrition. The situation was even more difficult for those nurses who suffered from beriberi because the disease caused their feet and legs to swell, making any kind of movement painful. Consequently, they could stand for only brief periods of time



and had to take short rests before returning to work.(36)

By 1944, the availability of food in the camp dropped to the critical stage. Children no longer played, while most adults who still had to work did what they could to conserve energy. During the last 3 months of imprisonment, their food intake was later estimated at less than 900 calories a day.(37)

Rescue finally arrived in February 1945. Actually, the internees were aware that American forces had returned to the Philippines in October of the previous year. A radio, fashioned by one of the male internees and hidden in the camp, had provided news on the course of the war.(38) And U.S. planes had occasionally flown over the camp. For 6 days in early January 1945, the Japanese guards left Los Baños. The internees woke up one morning and discovered all the Japanese had pulled out. Yet no one had any energy to do more than wonder what to do. Severe starvation

had made everyone mentally as well as physically lethargic; their thinking processes had definitely been affected. Then, just as suddenly, the Japanese returned. By listening to the secret radio, the internees heard that camps in and around Manila had been liberated. Rumors abounded that Allied forces had no idea that Los Baños existed and that they might be bypassed.(39) On 22 February 1945, word spread throughout the camp that the Japanese had been ordered to kill all prisoners. Added to the sense of impending doom were the manned machine guns, facing inward, all around the camp. Cobb, described at this point as a “mother hen” to the Navy nurses, directed her charges to continue their work schedule.(40)

The next morning, 23 February, after a terrifying night spent wondering if the Japanese would kill them all at first light, the internees saw paratroopers from the Eleventh Airborne, U.S. Army, descending from planes overhead. The idea of rescue

took a moment to sink in. Then they saw amphibious tractors (amtracs) carrying soldiers from both the U.S. Army and Filipino guerrillas crash the front gate. Startled and almost paralyzed by fear and malnutrition, the internees did not immediately realize that rescue was at hand. Time, they learned, was of the essence because Los Baños was well behind enemy lines.(41)

The rescuers organized the internees for the trip to the beach where they would cross the bay to Manila. Laura Cobb arranged for the transfer of patients from the hospital to the amtracs which carried the weakest and sickest. The rest walked the mile and a half to the beach. Although fired upon by Japanese snipers along the way and prodded continuously to hurry, the long line of freed internees took over 2 hours to reach the point of transfer to the beach.(42) There the nurses waited with the others as the amtracs made several trips across the bay. Once across, they waited another 3

hours for transport to New Bilibid at Muntinlupa which became their home for 10 days. Their first meal there consisted of beans and graham crackers.

Fighting continued all around them and casualties mounted. They worked at the hospital in the prison until relieved by fresh and well-fed Army nurses who wanted their Navy colleagues to stay and help with the wounded. Cobb, however, insisted her nurses were too weak and had orders to return to the U.S. Consequently, 10 days after their rescue, they rode in trucks back to Santo Tomás, passing parts of Manila littered with burned-out buildings and torn-up streets.(43) After a short stay there, the nurses boarded a C-47 for the long trip home. Their first stop was Leyte where Army nurses gave them uniforms which they wore on the next flight to Guam. It was close to midnight when the plane landed. During the stopover, they faced a group of reporters and members of the military who wanted

to interview them. After briefly describing their 3 years in the camps, Cobb responded to questions claiming, “I want to return to the Philippines. If I don’t, I’ll be finished with this war. I’ve been on the receiving end too long. Now, I’d like to be on the other side. I’m tired, but I want to see this war through.”(44)

From Guam, they flew to Kwajalein, Johnston Island, and finally, Pearl Harbor. They spent 2 days at the Naval Hospital on the base taking hot baths and using shampoo for the first time in over 3 years. They then donned new Navy nurse uniforms for the flight to the mainland.(45)

On 10 March 1945, they landed at San Francisco and stepped into a new role as heroes of the war. Even though they were very tired from the long trip, they again answered questions from the press before traveling to Oak Knoll Naval Hospital in Oakland. “We aren’t sorry we were caught in the war. We aren’t sorry one bit for the hardships—the experience we had,” said Cobb to a reporter from the *San Francisco Examiner*. The other nurses echoed her sentiments and reiterated their desire to return to the Philippines and help finish the war.(46)

The Navy, however, had other plans for them. The nurses spent several weeks at the hospital, recuperating. All had lost a considerable amount of weight. Cobb, for example, weighed 35 pounds less than before her capture.(47) Part of their treatment meant an adequate and generous diet. In 10 days after their libera-



LCDR Cobb descends stairs at Guam as the 11 Navy nurses continue their long journey home following liberation.

tion, each nurse had gained 7 to 8 pounds. Cobb later stated she was unable to recall specifically her first meal, but noted it did include meat, potatoes, bread, and butter. To the amusement of the reporters, all the nurses professed a liking for Spam.(48)

When deemed strong enough, each nurse received 90 days leave to visit their families. Cobb returned to Wichita where she stayed with one of her sisters and continued to regain her health. By that time, she had been promoted to lieutenant commander. The nurses received military medals for their service as well. All were awarded the Bronze Star and a Gold Star in lieu of a second Bronze. Cobb also learned she had earned the Defense of Philippines Ribbon, a Distinguished Army Unit Citation, and the Asiatic-Pacific Theater Ribbon with two Battle Stars.(49)

In December 1945, the Navy doctor with whom Cobb worked during the bombing of the hospital at Cañacao and Cavite Navy Yard, recommended her for the Legion of Merit. For unknown reasons, she never received it.(50)

After her well-earned leave, Cobb returned to active duty and was assigned as chief nurse at Treasure Island, CA. At a ceremony in San Francisco in February 1946, she was presented with the Avon Medallion of Honor for Women of Achievement. A committee composed of novelist Fannie Hurst, opera star Gladys Swarthout, and Dean C. Mildred Thompson of Vassar selected Cobb to receive the award which included a

\$1,000 Victory Bond for her “heroic and selfless work among the sick and wounded internees in Japanese prison camps.”(51)

Cobb attempted to remain on active duty, but the years of suffering from malnutrition finally caught up with her in 1947. While she had seemed intent on retaliation against the Japanese immediately after her release, her physical and emotional health was more damaged than she realized. Consequently, she retired in

1947, listing arthritis and a heart condition as the official reasons for her separation from the military. She then moved to Los Angeles, and worked in a sanatorium until 1964 when she returned to Wichita after the sudden death of one of her sisters. It was there she died in September 1981.(52)

Some members of the original group of 11 nurses survived just beyond the turn of the new century. Several had returned to the Philippines in 1980 for the dedication of a me-



CAPT Clyde Camerer, MC, welcomes Cobb to NAS Honolulu.

morial recognizing and honoring the nurses' wartime service. For the most part, however, they faded from the public memory.

Interest in World War II continues but with a focus on combat heroics. The story of these nurses reveals courage in the face of danger and a fortitude to survive under extreme conditions. Perhaps the fact that they remained in the camps together, leaning on one another for support and companionship contributed to their confidence and will to endure. Strong and effective leadership was undoubtedly a factor too. Cobb never yielded her role as chief nurse and understood the value of assigning her subordinates duties in the camp hospitals. From various recorded accounts, it is clear that their devotion and service to caring helped the other internees survive.

Their story adds another page to our understanding of the role women played in World War II. In a manner similar to what many "Rosie the Riveters" on the home front experienced, these nurses gained new confidence in themselves and in what they were capable of doing. They became less dependent on external forces and found strength within themselves. With that awareness came a new kind of freedom. Laura Cobb was part of this history. Her quiet courage and bravery represent a well-earned component of the larger history of women in general and of World War II in particular.

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Project Windstorm A Cold War Memoir

CAPT James Helsper, MC, USN (Ret.)

Part I

This is the story of the planning for America's first underground atomic explosion in 1951. Because of the widespread fear of the consequences, the project was scheduled to be carried out on an isolated island in the Aleutian Islands. The Navy was assigned the task to detonate this first underground bomb, principally to maintain secrecy and avoid publicity.

The Soviets had just exploded their first atomic bomb, the Korean War had begun, and President Harry Truman took the view that these events justified the re-arming of the United States.

The Seabees (the Navy's construction battalion) was selected for this assignment. In strictest secrecy, they and their equipment were shipped to an abandoned, tundra-covered island to build the infrastructure for the test. The tour of duty was expected to be 1 year. "As a physician, I had been selected by the Navy. However, I was only partially trained in surgery, but enough to care for a thousand men from every walk of life."

The following is part I of a series describing a Navy medical officer's unusual experiences during that tour of duty, and the minor role he played in the Cold War.

* * *

James Helsper was born in Minnesota and as a young boy lived and went to school in Pennsylvania and Rhode Island. Both his father and grandfather were pharmacists. Badly burned in an accident, Helsper was cared for by many physicians and soon began seeing them as role models, eventually determining that medicine would become his profession.

Following the attack on Pearl Harbor, Helsper enlisted in the Navy and was ordered to a college as an apprentice seaman.

At age 19, the Navy offered him two choices—flight school or medical school. "My parents convinced me that I could just as well serve my country as a doctor taking care of the wounded. I have often wondered what would have happened had I taken the other option."

Following graduation, Dr. Helsper continued with a surgical residency. The Korean War had just broken out and, with the Army short of qualified physicians, Helsper was assigned to a surgical ward at Madigan Army Hospital in Fort Lewis, WA. "We received Korean casualties from McChord Air Force Base, a short distance away, and felt that we were doing a good job, helping in the war effort in addition to continuing our training."

His next assignment was Port Hueneme, CA. "My 3-month 'fun' duty station was over, and it was time for war...or something really important!"



USS Aiken Victory (T-AP-188)

Photo courtesy of author

As I drove into Port Hueneme I saw it was the home of the Seabees. The medallion showing the bumblebee carrying tools and guns in his many hands would soon become very familiar.

The Seabees were the Navy's construction engineers. They were designated to build the runways and camps, as well as bridges and docks, and whatever else the Navy required. These men were referred to as the "Fighting Seabees" and were armed. They covered the whole spectrum of builders, plumbers, electricians, sheet metal workers, welders, and heavy equipment operators...whatever it took to build a base or an airstrip. Port Hueneme was their West Coast base, and it was a huge marshaling site for storing the equipment necessary for any job anywhere in the world.

The base consisted of several square miles of equipment storage areas and a small harbor area. Units assigned to a job were called construction battalions made up of workers and specialists necessary to perform the task. Officers, particularly warrant officers, were in charge of the groups of men required to complete the assignment. These warrant officers had been construction foremen in civilian life, and it became obvious in a short time that they were the ones

who would see to it that the job was completed.

The officers in the Seabees had a special designation on their uniforms showing four feathers in a diamond shape and an acorn on either side, specifying they were the Civil Engineer Corps of the Navy. They did much of the construction necessary outside the continental United States during World War II. A movie was even made commemorating them starring John Wayne. Their "Can Do" motto was legendary, as I would soon learn.

I located the officer of the day in the Mobile Construction Battalion [MCB 3] headquarters at 1755 hours, with just minutes to spare, according to my orders, and he greeted me with, "We didn't think you'd make it, Doc."

I held my tongue, but I felt like asking "What if I didn't." I signed the appropriate papers and was now part of MCB 3.

A Sailor took me into another room and showed me two dark khaki sea bags filled and sealed with padlocks. As he handed me the keys he said, "We took your measurements from your enlistment physical in 1942, Doc, and we hope the uniforms fit. Sign in here for your guns; Gunny hasn't had time to clean them up, but you can do that on the ship."

"Ship?" I blustered. "Where are we going?"

"It's a big secret, Doc," the Sailor replied, "but you'll find out soon enough." Then he added, "The ship sails with the tide at 1200 hours. Just be sure you're on it."

Wow! Sailing at noon, just 18 hours away! And, as he said, perhaps for a year...and no one knew where we were going.

Back in my room, I opened the sea bags. They were filled with cold weather gear, including long under-

wear, mukluks, and the strangest looking foul weather gear. There was a heavy wool uniform. Dark khaki shirts and pants completed the inventory. Amazingly, they seemed to fit. Everything smelled of mothballs and other preservatives.

This allowed some reasonable speculation for our destination. It must surely be north, and to the very far north, since there were also heavy fur-lined parkas, and foul weather coveralls made of something that looked like bright yellow oilcloth. The so-called "police action" turned to war in Korea was in a cold climate, but mukluks? No, it couldn't be there...but that's where the war was.

I took out the gun. It was the regular officer issue .45 caliber Colt automatic pistol, all wrapped in a thick greasy material that I later learned was cosmoline, a preservative dreamed up by the military. It was hell to clean out. There was another weapon, a .30 caliber carbine with a 30-shot clip, also encased in cosmoline. I wrapped them both carefully in thick wax paper and an outer canvas cover. Despite my care, I had cosmoline all over my fingers and spent half an hour trying to clean it off. I suddenly wondered why they were issuing me guns when I was a doctor! My God! All I learned about guns was a little .22 rifle, when I was in the Boy Scouts! They had said nothing about guns in our indoctrination at Fort Sam Houston, but then that was the Army, and I was back in the Navy now.

I decided to go to the bar for a drink, hoping there would be someone there who was a bit more garrulous, but the bar was almost deserted. The bartender told me everyone was home on his last night.

I asked his opinion about where MCB 3 was going. He would only say, "No one knows for sure, but I do

know it will be cold. I've seen the ship, and it's covered with cold weather road building gear and heavy equipment." He continued, "A detachment from the battalion was shipped over to Pusan in Korea a few weeks ago, but they're already back, and they say you guys are not going to Korea."

Now at least I knew something, even if it was where we weren't going!

The bartender—an active duty Seabee moonlighting in the bar—offered some more rumors. "Another small detachment was picked up a few days ago with all their gear and flown out of Point Mugu a few miles away, and they haven't been heard from since." I speculated about intentionally not making it on time, arriving after the ship had sailed, but my parents brought me up to obey orders, so there I was, and, of course, I would have no idea what I getting into until I was there. There's another conundrum to think about! Here I was, all alone in my last night in the continental United States with no one "in the know" to talk with. I fell asleep feeling a tad sorry for myself.

My wakeup call was at 0600 hours, and I slept past the call, but soon responded when someone came to my room and pounded on the door. The "pounder" was LTJG Richard Hood, MC, USN. "Hey, hey, hey, hit the deck," he shouted.

Though we were the same rank, he told me he was the chief medical officer on this expedition, and we would be working together for the next year or so. Dick was a fabulous happy-go-lucky guy from Louisville Medical School (class of '49), who also wanted to be a surgeon. He had to do his 2 years of general medical officer (GMO) duty before he could start his residency in one of the Navy hospi-

tals. He was taller than I and had a Texas twang to his voice (or perhaps it was Kentucky southern) and we became instant friends. He, too, claimed ignorance of our mission and its location, but said it was going to be cold.

The ship was tied to a pier in the small harbor on the Base at Port Hueneme. Except for a tug or two it was the only ship in the harbor. As Dick's wife drove us closer we could appreciate the large size of the ship, and we could see that it was covered with heavy road building equipment, each one being "winterized" with a cab for the operator and painted khaki color. The equipment was lashed to the decks with heavy chains and wire rope. The cargo holds, I was assured, were filled with more equipment, including what we would need for the hospital, as well as for the dentist. The ship—*Aiken Victory*—was named after a town in South Carolina. It was the classic Victory ship built by the Kaiser shipyards, and ubiquitous during the last war. It had a single stack and no special distinguishing features. We noticed cranes everywhere still loading cargo.

The ship was designated as a U.S. Navy ship. It was painted the dark gray of Navy ships, and there were gun emplacements forward as well as in the stern, but the guns were absent. It was a ship hired by the Navy and actually run by civilians. There wasn't much time to examine it from the shore as they were already signaling up the lines for our departure. Despite all the unknowns ahead I was excited!

Dick directed me down through the passageways to meet the commanding officer (not of the ship) but of MCB 3. By now I had learned that meant "Mobile Construction Battalion No. 3." Something else became obvious. We were going somewhere

really cold to build something. What and where were still mysteries.

We found the CO, a commander, a short and serious man in his mid-40s who was much impressed by his projected task. He greeted us very formally and offered his hand in a limp and perfunctory grip. He never cracked a smile. I noticed he had an Annapolis ring. This made him a "ring knocker" in Navy lexicon. The Annapolis ring became a rallying cry to others in a conference if the table was knocked with the ring. It signaled other Annapolis graduates to rally around and support whatever was being discussed.

I thought he must be one of those who went into the CEC Corps, the fighting engineers of the Navy, after graduating Annapolis. These were the officers who lead the Seabees. He was very stiff and formal. After shaking our hands, it was clear that we were dismissed, even though we had learned nothing of our mission or our destination.

Dick showed me his quarters, which were right next to mine. No luxury here, but it was as I had imagined, a small room with a bunk along the wall. Rather ominously, I spied a bunk board, which could be unfolded to prevent the occupant from falling out of the bunk in bad weather. I was certain it wouldn't be needed on such a large ship, but then I hadn't seen many Navy ships. There was a small porthole for a view of the sun or watching the sea. We found the toilets and showers down the passageway.

Our accommodations were on the starboard side, not far from the officer's mess, where a pot of coffee was always available. There were stewards to wait table, and linen tablecloths and napkins to add a touch of luxury to shipboard life.

Dick took me down to sick bay, where we met the ship's company corpsmen and our MCB 3 corpsman. An older Navy chief led our group. We were relieved to know we had someone who knew the Navy ropes and would keep us out of trouble. There was a pharmacy tech, an x-ray tech, and best of all, an OR (operating room) tech, so perhaps this wouldn't be so bad. Altogether there were 10 corpsmen, from the chief through 1st, 2nd, and 3rd class rates, and three young men who were "strikers" learning to be corpsmen.

After all I had endured to become a surgeon, the worst thing that could happen would be to be assigned to a duty station where we couldn't perform surgery. But no one, absolutely no one, knew where we were going or what we were going to do.

Dick told me that all the men had gone through considerable psychological testing in preparation for this top secret and very important mission. There had also been a complete physical evaluation of each man. Dick had done all these and had excluded any potential troublemakers as well as anyone who was not physically fit. Among the men in the battalion most were reservists who had had good jobs in construction trades in civilian life. Most of the older men were experts in their trades, and many were contractors. The younger men were mostly "strikers" who wanted to learn a trade. The strikers were well motivated to do a good job, learn a trade, and get Navy pay while doing so, knowing they could look forward to a good civilian job when their Navy tour was over.

Dick said he had been even more careful in selecting the corpsmen for this mission. He and the chief had chosen only those who were competent and well adjusted for a long and

strenuous tour of duty. It wouldn't take long to learn if the right men had been selected, for we would soon be depending upon one another.

We heard a few long blasts on the ship's horn, a deep resonant noise

heard throughout the ship. We were leaving, and I suppressed a panicky feeling that I could no longer tell anyone anything about where I was going or for how long. Could I live for a year isolated from the rest of the

world? We were cutting all but military communication links. We were on our way! □

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The Clinic Management Course

Howard S. Steed, Ph.D.
LCDR Barbara CailteuxZevallos, NC, USN

Education that works, imagine that. You are a lieutenant (j.g.) Nurse Corps officer with 2 years of inpatient ward experience and are now assigned as the clinic manager for a busy primary care clinic.

- You just completed your family practice residency and have been assigned as the department head of a family practice clinic.
- You are a hospital corpsman that has come from a surgical ward and are newly assigned to a primary care clinic and are responsible for template management.

Finding yourself in this situation is not too unusual in Navy medicine, so how do you survive? Being a question of great concern to the Bureau of Medicine and Surgery, in the fall of 2000 the Optimization Champions at BUMED determined there was a need for an intensive course to assist clinics in Navy medical treatment facilities in their optimization efforts. Optimization was adopted as an initiative to maximize the operation of

Navy medicine across the world to improve primary care clinic effectiveness and efficiency. A team from BUMED (MED-53 – Education and Training), under the direction of CAPT Jane Mead, working with CAPT David S. Wade, (then Deputy Director, MED-05) was tasked to develop the curriculum for a Clinic Management Course and conduct the initial year of course offerings.

Initially, the team used the information collected through a series of 16 focus groups from various clinics operating in the U.S. From these focus groups the following elements of the curriculum were defined as crucial to the course: Business Rules, Population Health, Template Management, Data Analysis, Change Management, and Staff Roles and Responsibilities. It was determined that curriculum would be taught over a three and a half-day period and ideally to teams of five individuals from specific clinics, with an emphasis on primary care clinics. It was requested

that team members from participating clinics have at least 1 full year left before reassignment in order to allow the team time to implement the new optimization practices at their respective clinics. Ideal team members consisted of the Clinic Manager, Template Manager, Department Head, a Provider and support staff, i.e., nurses, corpsmen, etc.

A team of subject matter experts was assembled to define the important learning points and make recommendations to the MED-53 staff for specific course/topic content. Pilot course instructors were selected from the subject matter experts whose expertise was respected throughout Navy medicine. A schedule of classes was developed and initiated in March of 2001, less than 6 months after the planning began.

It was a very ambitious schedule! Beginning in Bethesda, MD, the course traveled to Jacksonville, FL, Portsmouth, VA, Rota, Spain, San Diego, CA, Bremerton, WA, and fi-

nally to Okinawa in October 2001. The road-weary instructors, CAPT David Wade (Business Rules), CAPT Thomas McGue (Template Management), CAPT Sharon Sebbio, and CAPT Sandra Bibb (Population Health), CDR Kevin Moore and LCDR Barbara CailteuxZevallos (Change Management), CDR Sandra Saunders (Staff Roles & Responsibilities), and CDR Susan Galloway (Data Analysis), ably assisted by the course coordinator from MED-53, LCDR CailteuxZevallos, taught a total of seven complete courses. Teams from 45 clinics involving a total of 191 students attended these seven pilot courses. In addition, 10 individuals from Navy IG, HSOs, Population Health Departments, etc., observed these courses.

Following each of the pilot courses, end-of-course surveys were completed. This data indicated that 98.4 percent of the students indicated the course was relevant to their job while 93.5 percent indicated they would use the course materials in their present job. Furthermore, 90.8 percent of the students felt the course was relevant to their careers and 96.3 percent would recommend this course to their peers. Each course concluded with a Capstone Exercise. During this exercise each team was charged with the development of an optimization plan for their individual clinic. Optimization plans were presented to the class for discussion and improvement. Instructors served as a mock ESC and

provided productive feedback on the Student Team Optimization Plans. As a result of this exercise, each team was then prepared to return to its home clinic and brief their commanding officers and ESCs on recommended plans to optimize the operations in their clinic.

Post-course surveys were mailed to each of the 45 teams who attended the course approximately 6 months following their attendance in order to evaluate the effectiveness of this training. Responses were received from 25 of the 45 teams, or 55.6 percent.

83 percent of the teams reported an improved patient flow process.

72 percent of the reporting clinics reported developing new business rules.

84 percent of the teams reported modifying templates since the course resulting in an 80 percent increase in appointment availability.

52 percent of the respondents reported their primary care visits per available clinician FTE had increased since the course, with 50 percent of the respondents indicating increases from 1-10 percent, 46 percent of the respondents reported increases from 11-25 percent and 4 percent reported increases from 26-50 percent.

Another benefit of the Clinic Management Course was the introduction of the Population Health Navigator. Developed by CDR Mark Turner, MC, who is assigned to Naval Medical Information Management Com-

mand (NMIMC), the Population Health Navigator allows clinic personnel to review patient demographics in order to identify and focus on areas of population health to meet and improve patient care needs for each individual clinic.

CAPT Wade commented during his presentation (Business Rules) that “Navy medicine is given approximately 3.5 billion dollars each year to complete its healthcare mission. Of this 3.5 billion dollars, approximately 1.7 billion are spent by Claimancy 18 activities accomplishing 70 percent of the patient care for our eligible beneficiaries with another 1.6 billion being spent paying for the remaining 30 percent of medical services provided by the Managed Care Support Contractors.” This is a very lopsided expenditure of Defense Health Program funds! The ultimate goal of Optimization is to function more efficiently and recapture these patients and funds back into the Navy medical system. The impact of the Clinic Management Course is helping accomplish this goal. This is just another example of Navy education that works!

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The Clinic Management Course “sails onward” in support of the Military Health Systems

Optimization Goals of:

- **Force Health Protection**
- **Population Health Improvement**
- **Increased Access**
- **Improved Satisfaction**

A Facelift for *COMFORT*



Shipyard photos by HM1 Jim Moyer, NMETC.



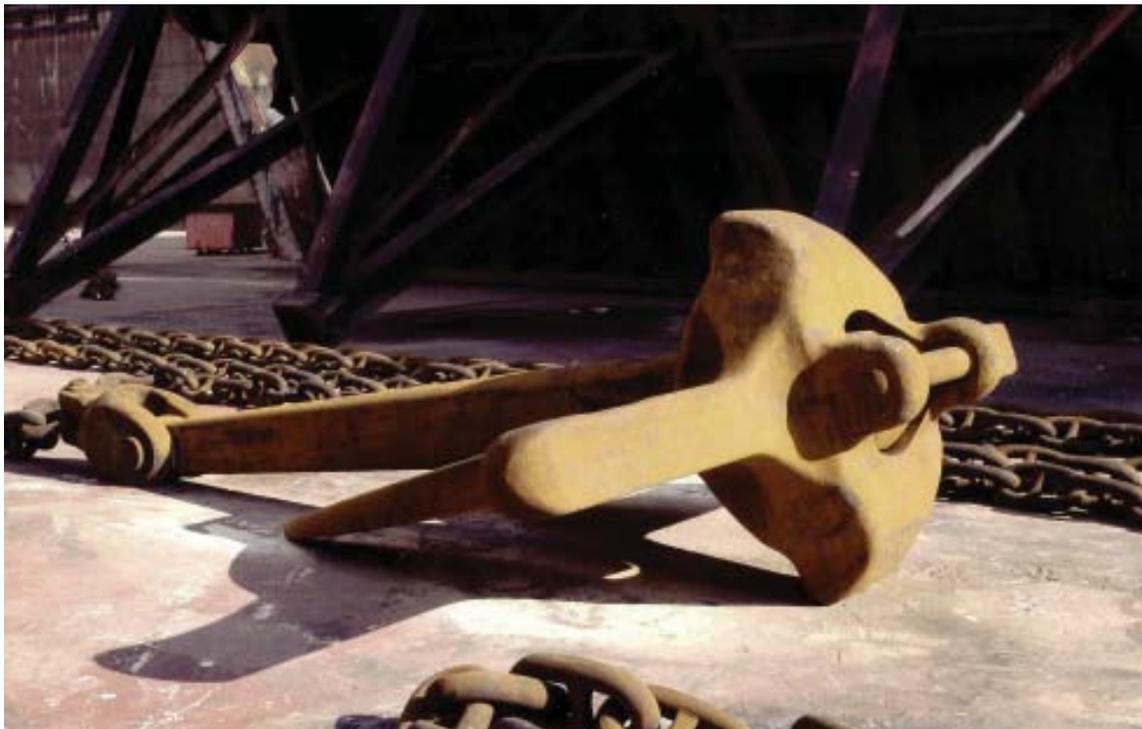
Last spring USNS *Comfort* (T-AH 20) put into the Baltimore Marine Industries shipyard for routine maintenance. Once high and dry in the yard's graving dock, workmen scrubbed marine growth from *Comfort's* bottom, serviced her propulsion system, through-hull fittings and propeller, and applied fresh paint to her hull. The hospital ship





needed to function and look her best as she prepared to get underway for an upcoming deployment to the Baltic nations of Lithuania, Latvia, and Estonia.

In the 15-29 July exercise involving more than 3,500 personnel from seven nations, *Comfort* participated in conducting rescue, humanitarian assistance, and disaster response.



Baltic tour photos by HM2 Katherine Castillo, NNMETC.



A Lithuanian military member receives care aboard the hospital ship.



On its way to the Baltic, *Comfort* docked at Southampton, England where physicians and nurses from the Baltic, the United Kingdom, and the U.S. became familiar with the hospital ship's layout and operation. Here, royal guest Princess Ann "inspects the troops."

Lithuanian patients treated during *Comfort's* last Baltic deployment and their families return for a visit.



In caring for his patients, CDR Terrence Dwyer required some assistance. Here an English speaking Lithuanian provides translation service.

Navy Medicine in Newport, Rhode Island

CDR Peter J. Peff, MC, USN

The history of Navy medicine in Newport, RI, revolves around Coaster's Harbor Island, a small island in Narragansett Bay just north of Newport Harbor. Home to the Naval War College and a large part of Newport Naval Station, it was named by Nicholas Easton and sons Peter and John in 1639. Rejected from the Massachusetts Bay Colony, they sailed down Narragansett Bay from Portsmouth to what was then the summer fishing grounds of the Wampanoags and founded Newport. The large, deep harbor was ideal for ships, and as maritime trade blossomed, merchant ships shared the bay with small coastal boats, privateers, Royal Navy vessels, and the odd pirate ship.

But along with the benefits of trade came exposure to diseases. A ship from Newport or nearby Bristol might return from Africa or the West Indies with malaria, yellow fever, or some other tropical disease. Smallpox was first reported in Rhode Island in 1690, and in 1716 a quarantine hospital was built on Coaster's Harbor Island, followed in 1721 by a second building "to accommodate persons from sea until it was ascertained if they had smallpox or any other contagious disorder." (Williams, Thomas J., 1937, *Coaster's Harbor Island and the Newport Naval Training Station, Their Activities and Growth*. U.S. Naval Station, Newport, RI).



Laboratory class at the hospital school, circa 1917-19.

Photo from BUMED Archives

Some maps of the period identify the island as "Hospital Island" or "Pest Island." In 1753 the Town of Newport designated a boat to carry smallpox suspects to the island. During the Revolutionary War the occupying British forces used Coaster's Harbor Island for a quarantine station. In 1792 the island was used as an isolation place for newly vaccinated townspeople. Some years later midshipman Oliver Hazard Perry, a local boy, was dropped off on Coaster's Harbor Island along with his shipmates after yellow fever broke out aboard their vessel.

In 1819 Coaster's Harbor Island was selected as the site for a poor asy-

lum, which was also used to house the insane and town drunks. A series of hospitals were built nearby on the island for contagious cases. The asylum inmates could view their final resting place in the nearby graveyard, until in 1883 this was obliterated by the construction of the Naval Training Station. Old gravestones dating from 1761 were found on a steep slope to the north of the tennis courts near Gate 1. The graves are believed to lie nearby, possibly under the courts.

As a result of British depredations and trade competition from Boston, the Newport economy slumped after the war. Newport became a quieter

place for a time but would later play an increasing role in the Navy. The first naval institution in Newport was the Naval Academy, which was temporarily moved to Newport in 1863 during the Civil War, returning to Annapolis in 1865. Next was the Torpedo Station on Goat Island in 1869.

When the town of Newport founded Newport Hospital in 1873, its stated goal was to provide care to the poor and to mariners. The U.S. Treasury agreed to pay 95 cents per day for each seaman treated and 8 dollars per death for burial expenses.

After the Naval Training Center was started in 1883, sick call was held onboard the training ship *USS New Hampshire*, later *USS Richmond*, and then *USS Constellation*. There are references to a naval hospital in Newport in 1889 commanded by CAPT William Braisted, later Surgeon General, who lived in an apartment in the hospital.

In 1896 a three-story wooden hospital building was built on the northeast corner of Coaster's Harbor Island on land deeded to the Navy by Newport via the State of Rhode Island in 1881 for use as a Naval Training Station. With the opening of the Training Station in 1883, the large number of recruits coming from around the country and living in close quarters raised the problem of disease epidemics. Many came from isolated rural areas and lacked immunity to some of the common infectious diseases, so they were divided into several groups and closely observed. If illness broke out, the affected group was quarantined until the mini-epidemic had run its course.

Other Navy commands provided work for medical, too. Periodic explosions rocked the Torpedo Station, which designed and tested torpedoes, fast torpedo boats, and the Navy's first

submarine, *USS Holland*. Other commands were the Naval War College (1884), the Naval Coaling Station, Melville (1900), and part of the Atlantic Fleet.

In 1881 Commodore Stephen B. Luce asked the town for permission to use a vacant hospital building for the new Naval Training Station. In 1885 the asylum inmates were moved to a new home on Broadway and the building was rededicated by Admiral Luce as the United States Naval War College. After the War College moved to Luce Hall in 1892, the old building served as the Administration building, then as Quarterdeck of the Naval Station, and finally as the Naval War College Museum which we see today.

In 1910 the Navy bought a 13-acre parcel of land on the adjacent mainland for a new naval hospital, dedicated in 1913. This picturesque site on the bay was the location of an elegant three-story Victorian-style mansion, the Wissahickon, built by Robert L. Maitland in 1852, then sold to Daniel T. Swinburne, descendant of the seafaring Arnolds and Tews. His son William attended Annapolis and became one of the few officers to serve both in the Civil War and World War I, rising to the rank of admiral. To make room for the hospital, the house was moved to the corner of 21 Bayside Avenue and Sycamore Street.

Newport has been the set for at least 14 movies, one of which, "A Nation's Peril," directed by George Terwilliger, was filmed in 1915 on the grounds of the Naval Hospital and adjacent harbor. Earl Metcalf starred as the young Navy lieutenant who defends the coast against the enemy landing. Naval reservists played roles on both sides. Other movies filmed in Newport were "High Society," "The Great Gatsby," "The Bucca-

neers," "The Star Spangled Banner," "Wind," "Reversal of Fortune," "Mr. North," "True Lies," "Amistad," and "Me, Myself, and Irene."

The new hospital was a three-story T-shaped brick building in Italian Renaissance style. Modern features were an electric elevator large enough for a cot, a trunk-sized steam disinfectant, filtered water, wall vacuum service throughout, dumbwaiters, sterilizers for each ward, wheeled bathtubs, lead-lined x-ray rooms, and for resuscitation purposes, the "pulmotor," an early artificial ventilation device.

As expected, the Naval Hospital greatly expanded its capacity during and after the two World Wars. Ward expansion changed its shape to an "H." During World War II there were 217 permanent beds and 614 additional in temporary construction. The "emergency capacity" was rated at 1,149, but at one point in 1945 they found room for 1,315. Hospital staff rose from 245 to 770.

Nearby was stationed a good part of the Atlantic fleet—6 battleships, 8 cruisers, 30 destroyers, 2 submarines, 2 destroyer escorts, and 2 supply ships. At one time, 125 ships were based in Narragansett Bay as a whole. Quonset Point across the bay to the north was the Navy's largest airbase and supported a carrier fleet.

A retired chief hospital corpsman recalled the camaraderie and teamwork he felt during his work at the Naval Hospital. Port and starboard watches were the rule, but when things were slow at night he could take call from the hospital pier, drop his fishing line in the bay, and still be signaled by flashlight if he was needed.

In those days one measured IV flow rates by counting drops and penicillin had to be dosed every 4 hours

to treat infections. When off-duty, if one didn't want to brave the bars and clubs on Thames St. downtown, the Navy owned a house near Sachusett Point where you could dance to Bing Crosby music.

Several disasters over the past century taxed the medical resources of the Newport community and showed the excellent spirit of cooperation between the military and civilian communities. In 1916 care and support was provided to British and Canadian victims of an attack by a German submarine off Block Island. Hans Rose, the U-53 commander, calmly picked a target and, following the old honor code, allowed the passengers to debark from the ship before he fired. The remaining ships were told to wait their turn, which they did, having no alternative. Our naval vessels could only stand by to rescue victims, since the U.S. was a neutral at this point in the war. Strange as it seems, only 1 day earlier Captain Rose had made a courtesy call on the senior officer at the Naval Training Center after U-53 was piloted into Narragansett Bay by a US Navy submarine D-2!

Six months later the U.S. entered the war. No other U-boat visits to Newport are documented, although there is an unconfirmed report of a U-boat surfacing off First Beach to conduct espionage during World War II.

In 1917 the Naval Hospital provided temporary wards, staff, and drugs to care for civilians stricken during a severe diphtheria epidemic which overwhelmed the civilian hospital. And in 1918 during the severe influenza epidemic there were over 1,000 patients under treatment there at one time.

The Naval Hospital and its personnel came to the aid of victims of sev-

eral maritime disasters. In 1925 SS *Mackinac*, a passenger steamer on its way back to Providence, suffered a boiler explosion just after leaving Newport Harbor. Fortunately the Navy Scouting Fleet was anchored in the Bay, and rescue boats were immediately launched. Within 45 minutes the first casualties were landed at the Naval Hospital pier and the officer of the day was informed that many more were coming. Rapid action by the fleet and dedicated care by Navy medical officers, nurses, and corpsmen, as well as civilian volunteers, helped to save many, though 53 eventually died. On 26 May 1954 another tragedy occurred when the USS *Bennington* (CV-20) suffered a massive explosion off the coast of Newport killing 103. Helicopters from NAS Quonset met the ship as it entered Narragansett Bay to speed transport of casualties to the Naval Hospital, and civilian doctors and nurses responded to the need for help. On 8 August 1959 the Naval Hospital assisted the civilian hospital in the care of victims of the collision between SS *Gulfoil* and SS *Graham* in pea soup fog off the coast of Newport, between Fort Adams and Jamestown.

In 1991 after 78 years of service the Naval Hospital required major renovation or rebuilding. Rather than constructing a new hospital, the Navy accepted an offer to share the excellent facilities at the local hospital in Newport, which were underutilized at the time. On 29 August 1991 Naval Hospital Newport closed and inpatient care moved to Newport Hospital as an "external partnership for inpatient care." An arrangement was worked out which allows Navy patients to be cared for there by Navy medical officers. Navy doctors contribute to committee work, education, and other hospital activities, and have

improved access to subspecialty consultants for their inpatients. Outpatient care continues in the Newport Comprehensive Health Care Clinic dedicated in 1998.

The old Naval Hospital stands empty now, a neoclassical backdrop for the command PRT run and picnics. As we face the uncertainties of 2003, we may look back with interest to see how our predecessors tackled the problems of their day, especially since some of the "vanquished" diseases may suddenly appear again in our midst. We anticipate that Navy medical personnel at Newport and their civilian counterparts will continue to work together, helping each other accomplish their missions.

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Emergency Response Codes in Navy Health Care Facilities

A Call for Uniformity

CAPT Steve Nichols, MSC, USN

The call comes in to the Hospital Information Desk, “This is HN Wilson on 8 West. We have a Code Blue!” Seconds later, the 1MC blares to life throughout the facility, “Code Blue, Ward 8 West; Code Blue, Ward 8 West.” The Code Blue Team arrives on the scene within minutes and completes a rapid, highly choreographed series of actions to resuscitate and stabilize the patient. The result—another life saved and a family reassured.

A fairly common occurrence in a hospital? Certainly, except that in some Navy hospitals that urgent call to action—“Code Blue”—may have been met with no action at all. Most of us have heard the term Code Blue, probably the most common name for a cardiac arrest response. However, not all Navy medical and dental treatment facilities (MTFs/DTFs) use “Code Blue” to signify a cardiac or respiratory arrest emergency.

A recent review of emergency response codes at 30 Navy MTFs and DTFs (17 inpatient, 6 outpatient, and 7 dental units) found a wide disparity

in the designations used for typical situations or events. Table 1 identifies specific code designations and their frequency of use at the contacted facilities for seven common emergency response events.

The codes “blue,” “red,” and “pink” were most commonly used by these facilities to designate cardiac arrest, fire, and infant/child abduction, respectively, but their use was clearly not uniform. Even for the most common medical emergency (at least to television audiences), three different codes are in use to announce a cardiac arrest or emergency lifesaving situation—Code Blue, Code 4, and Code 800. The limited consistency in evidence within the first three event categories disappeared completely among the remaining emergency response code situations at the same facilities.

By comparison, consider the use of emergency response codes onboard Navy vessels. The standard material conditions of readiness codes (X-ray, Yoke, and Zebra) used onboard Navy ships indicate the degree of access and

system closure in effect at any given time. Can you imagine our Navy using different material conditions of readiness codes on different ships? Think of the damage control nightmare that could create! How about each ship using a different “Collision Alarm” signal? Or what would happen if the Fleet-standard, “down and aft on the port side, up and forward on the starboard,” were only selectively applied and enforced to control the crew’s movements during emergencies? It’s unlikely that changes to alarms and response plans for any of these emergency situations would happen without a standard fleet-wide application. Because most emergency codes and alarms are standardized throughout the fleet, transitioning from one Navy ship to another is fairly simple in terms of damage control efforts and responses to common emergency situations.

As a former hospital corpsman and now a healthcare administrator, I have responded to many of these emergency codes over my career, both ashore and afloat. However, unlike

Table 1: Common Emergency Events and Corresponding Response Codes at Select MTFs/DTFs

Cardiac Arrest	Fire	Infant/Child Abduction	Psychiatric Emergency	Security Emergency	Bomb Threat	Mass Casualty	HazMat Emergency
Blue (25)*	Red (20)	Pink (15)	None (11)	None (20)	None (15)	** (16)	None (24)
4 (2)	100 (5)	None (10)	Green (7)	Green (3)	Black (5)	None (8)	November (2)
None (2)	None (4)	Green	Yellow (5)	Yellow (2)	Yellow (3)	Green (4)	Magenta (2)
800	Dr. Red	Baby	Romeo (3)	Romeo	Romeo	Delta (2)	Black
		500	400	300	200		Yellow
		Dr. Lindbergh	Dr. Armstrong	Brown	Brown		
		Amber	Strong	Strong	Orange		
			White	66	Green		
					Purple		
					Red		

*Numbers in parenthesis (X) indicate frequency of use (more than once) among the 30 MTFs/DTFs reviewed.
 ***"Mass Casualty" announced over the facility broadcasting system; no specific code used.

aboard ship, I have had to learn a new “code language” at each shore health-care facility to which I was assigned. Do we really want our key emergency responders—the physicians, nurses, and cardiopulmonary and respiratory technicians who respond to a “Code Blue”—to learn a new set of codes each time they transfer to a new facility? Can we afford even a brief hesitation that may result from their “new facility - new rules” confusion at precisely the time when we want them to be the most responsive, confident, and focused? Maybe there is a better way.

Standardization of emergency codes for all hospitals and health care facilities worldwide would be ideal, but the “curing world hunger” approach is not a realistic goal in any near term scenario I can imagine. Establishing uniform emergency response codes throughout Navy medicine seems to be an improvement effort that could readily be accom-

plished. The senior leadership at our healthcare facilities needs sufficient latitude to establish policies and practices that are suitable to the circumstances within and around their organizations. But for the reasons cited above, this is a case where standardization across our enterprise makes complete sense. This improvement effort also clearly fits into both the Readiness and the Optimization legs of the Readiness, Optimization, and Integration triad that our Surgeon General has set forth for Navy medicine.

Internet research and anecdotal evidence supports the contention that this lack of response code uniformity is not unusual in the healthcare industry. Civilian hospitals have a similarly varied list of codes used to designate the same emergency event from one facility to the next.(1-4) However, a large portion of our staff members—the military personnel and employed military family members—often

transfer to different facilities more frequently than our civilian counterparts. As a result of our high staff turnover, the lack of emergency response code uniformity may be even more troublesome in our military healthcare settings.

Some civilian organizations and jurisdictions have begun taking steps to standardize the emergency code designations in the hospitals under their oversight. For instance, a new 2001 Maryland state law required the Secretary of the Department of Health and Mental Hygiene (DHMH) to develop a uniform set of emergency security codes for hospitals in the state.(5) Each hospital must implement the provisions of the emergency security codes within 2 years of DHMH’s adoption of regulations.

The tragic death of several staff members at a California hospital in 1999 led to an effort to standardize emergency codes.(6, 7) Following the incident, the Healthcare Association of Southern California (HASC) surveyed 442 California hospitals in 2000. Ninety percent of the 289 responding hospitals used the same codes for fire (Code Red) and medical emergency (Code Blue), but there were more than 40 different codes used for infant abduction and over 60 for a combative person alarm. The survey results led to establishment of 11 standardized emergency codes shown in Table 2 for use in member hospitals. A HASC business subsidiary, AllHealth Security Services, also created a booklet, “Healthcare Facility Emergency Codes: A Guide for Standardization,” to assist a medical facility’s staff to respond in a uniform way to situations that may occur in and around the hospital.

Hospitals in Santa Clara County in northern California also began using the uniform set of 11 emergency

codes on 1 January 2003.(8) Finally, in a July 2002 risk analysis report, ECRI (formerly the Emergency Care Research Institute), an independent nonprofit health services research agency, recommended that healthcare facilities nationwide adopt a uniform set of emergency response codes modeled after those developed by HASC.(9)

This call for uniformity does not mean that every Navy healthcare facility must use the same set of codes and event designations without exception. Not all facilities will need to use all the standardized codes (e.g., some activities have no need for the Helicopter Operations code). In addition, the majority of our facilities are stand-alone buildings with their own internal public address systems, but some medical/dental units, like small satellite clinics, are located within the physical plant of another command. In those cases, use of the emergency response codes established by the host command may be more appropriate. In other limited cases, there may also be good reasons for a specific command to use something different than a standardized Navy medicine response code. However, these exceptions to the standard codes should be minimal.

No consolidated data is available about incidents in which healthcare facility personnel may have responded incorrectly due to confusion over emergency response codes. Still, the need for standardization seems almost intuitive. To wait for an unfortunate incident to prompt us to change runs contrary to Navy medicine's concerted patient safety efforts and our strong preventive healthcare approach. The lack of emergency code uniformity and the high mobility of our MTF and DTF staff combine to create a potentially

tragic "accident waiting to happen" scenario.

As a key defensive weapon system in our Navy's and our nation's arsenal, Navy medicine needs to act swiftly to shore up this very important defensive system within our own commands and units. The patients and visitors at our healthcare facilities, and the dedicated men and women who staff those facilities, deserve no less. The 11 standard codes established in southern California may serve as a model for our system, or at least as a suitable starting point for discussion. Regardless of the codes selected, the need is clear and the time is now to establish and implement a uniform set of emergency response codes in Navy medicine.

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CODE	EVENT
Red	Fire
Blue	Medical emergency - adult
White	Medical emergency - pediatric
Pink	Infant abduction
Purple	Child abduction
Yellow	Bomb threat
Gray	Combative person
Silver	Person with weapon and/or hostage situation
Orange	Hazardous material spill/release
Triage Internal	An internal disaster
Triage External	An external disaster

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A Survey of Sexual Risk Behavior and Condom Use of Males in the Navy

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Anne E. Norris, Ph.D., RN, CS

Peacetime sexually transmitted disease (STD) infection rates among US military personnel are two to five times higher than in the US civilian population.⁽¹⁾ In this light the development of effective military HIV/AIDS and other STD prevention programs assumes vital and immediate importance. Recent HIV seroconversion data reveals that 95 percent of those newly infected are young, active duty Navy and Marine Corps enlisted personnel and that 97 percent of them are male.⁽²⁾ Further, although African-Americans comprise only 19 percent of the active duty, enlisted population, HIV seroconversion data indicate that 60 percent of those newly infected are African-American.

According to Lyerly, Barry, and Miller, military personnel are among the most susceptible populations to HIV/AIDS and other STDs.⁽³⁾ These authors note that military personnel are: a) mostly young and sexually active, b) often away from home and

influenced more by peer pressure than social orthodoxy, c) inclined to feel invincible and take risks, and d) surrounded by opportunities for sex. They argue that deployment to unsettled regions increases the chances of military personnel acquiring HIV and other STDs. Of concern is that 9 years after Lyerly, et al. ⁽³⁾ called attention to the especially high risk for military personnel, 77 percent of Navy respondents to the 1999 HIV Needs Assessment Survey of military active duty personnel identified unprotected sex while deployed as a serious problem.⁽⁴⁾

The HIV/AIDS pandemic now represents a threat not only to social/economic integration and political stability, but also to national and international security and peace in many parts of the world. Moreover, the Navy Environmental Health Center recently identified HIV disease to be a threat to overall readiness, costing approximately \$40,000 each to recruit and train additional personnel who are

lost to HIV disease. In this light, the development of effective Navy HIV/AIDS prevention assumes vital and immediate importance.⁽⁵⁾

Because of the direct contact nurses have with high risk individuals in a variety of settings within the military environment, and because of nursing's focus on primary prevention, the TriService Nursing Research Program (TSNRP) funded the study described in this article, "HIV Risk Behavior and Condom Use: Collecting Data for Prevention." The study procedures and survey questionnaire were then approved by BUMED and COMNAVAIRPAC.

The goal of the study is to produce data that can be used to design effective HIV and other STD prevention interventions for naval personnel who are most at risk. Study data should clarify whether less intensive, more general health education efforts are warranted for other at risk enlisted personnel. Although civilian population research regarding condom use

and sexual risk behaviors has been done, it is not clear that these results can be extrapolated to the military. The bulk of research regarding African-American and Hispanic ethnic groups has been conducted with urban, low-income civilian populations. These populations differ from the military in several ways including: income, education, job assignments/profession, and living environments. It is questionable whether interventions designed for these populations would be effective in a military population. This study provides data that can be used to design effective HIV and other STD prevention interventions for military members. Additionally, it provides basic data regarding the prevalence and risk behaviors of young Navy enlisted personnel.

Goals of this study are:

1. To determine the differences in the levels of condom use and sexual risk behaviors for various ethnic groups (Caucasian, African-American, Hispanic, Asian/Pacific Islander, Native-American) male, active duty, enlisted personnel in pay grades E-1 to E-4;
2. To ascertain the social context (use of alcohol, type of partner) in which unprotected intercourse is occurring in these different ethnic groups;
3. To detect ethnic differences in psychosocial variables underlying consistent and inconsistent condom use which are amenable to intervention;
4. To articulate the impact of psychosocial (self-efficacy, norms, attitudes, beliefs, construct accessibility) and social context (alcohol use, type of partner, acculturation) variables underlying consistent and inconsistent condom use, and how this impact varies within the predominant ethnic groups for active duty, enlisted men



Figure 1

working in pay grades E-1 to E-4 (Caucasian, African-American, Hispanic, Asian/Pacific Islanders).

A major focus of this study is to determine ethnic differences in predictors of condom use. This will allow development of culturally specific interventions. Culturally specific interventions will allow an understanding of the psychosocial factors underlying a behavior in a specific ethnic group and are congruent with participants' cultural values and lifestyles. (6,7)

This study is guided by a theoretical model of condom use that integrates constructs from the Health Belief Model(8), Theory of Reasoned Action(9), Social Cognitive Theory (10,11,12), and Construct Accessibility Model(13) as seen in Figure 1. These studies have been found to be predictors of condom use and are potentially amenable to development of intervention strategies. Acculturation and the degree to which an individual is influenced by the dominant English

speaking culture in the U.S. are added to this theoretical model because acculturation has been found to influence condom use and sexual risk taking behavior.(14) The intent is to develop a richer explanation of condom use that incorporates overlapping and complementary concepts from these various theoretical models rather than to argue for the merits of one model in particular. This enhanced explanation may then be used to develop effective interventions for male, active duty, enlisted personnel who are most at risk for HIV and other STDs.

According to the Health Belief Model, negative and positive beliefs about condom use are seen as benefits and barriers to engaging in condom use behavior.(8) Perceived social, psychological, and physiological benefits (or lack thereof) of condom use have been associated with predictable increases and decreases in condom use.(15) For example, beliefs about the negative effects of condoms on sexual pleasure are associated with

less consistent condom use or a decreased likelihood of ever using condoms. (16,17)

According to the Theory of Reasoned Action (TRA), condom use is influenced by beliefs about the positive and negative consequences of condom use, attitudes, and subjective norms concerning that behavior.(9) The beliefs about consequences are akin to the beliefs about costs and benefits identified by the Health Belief Model and are theorized to determine attitudes (positive or negative feelings about condoms). Subjective norms are perceptions the individual has of other's attitudes regarding condoms. Hence, in this study participants are asked how much they think their sexual partner wanted to use a condom. Jemmott has successfully used this theory along with Social Cognitive Theory to understand condom use and design condom promotion interventions for African-American youth.(18)

According to Social Cognitive Theory, self-efficacy is the most central and pervasive motivator and regulator of behavior.(10,11,12) Self-efficacy is the belief that one can engage in a series of actions that will make one successful in carrying out a specific behavior. This belief predicts the likelihood that the individual will engage in that behavior and how much effort they are willing to expend and for how long in attempting to be successful in accomplishing this behavior.(10,11,12) Consistent with this theory, self-efficacy regarding one's ability to use and persuade partners to use condoms has been found to be an important predictor of condom use.(19,20)

The Construct Accessibility Model holds that particular constructs such as beliefs and attitudes are most likely to influence behavior when they are

accessible (activated) in memory.(21) For example, while the theories reviewed so far hold that different kinds of beliefs are important determinants of behavior, this model predicts that these beliefs are not likely to be acted upon unless they are in an accessible state in memory. Beliefs and other kinds of constructs become accessible when individuals talk, read, or think about issues relevant to the construct. The effects of highly accessible constructs on behavior have been demonstrated in a variety of contexts including pregnancy risk avoidance (22,13), and condom use behaviors.(21,23)

Our study consists of a survey of young male active duty, enlisted personnel regarding (1) sexual behaviors that put them at risk for HIV and other sexually transmitted diseases, (2) condom use, (3) psychosocial (beliefs, self-efficacy, norms, construct accessibility), and contextual factors (alcohol use, steady vs. casual partner, acculturation) that influence condom use and risky sexual behavior. The sample is comprised of active duty, enlisted personnel in pay grades E-4 and below who are serving on four of the aircraft carriers in the Pacific Fleet under conditions of deployment. The survey questionnaire is distributed on the aircraft carriers with the approval of the commanding officer.

Female personnel are excluded because Navy seroconversion data indicates that females are at lower behavioral risk for exposure to HIV as well as other STDs.(2) Additionally, it should be noted that the scientific merit of women's participation would be quite limited. Their data would only be useful for descriptive purposes. It could not be used to examine the theoretical issues needed for designing appropriate interventions. Main effects for gender that

ignore ethnic differences can be misleading and should not be used as a basis for designing interventions: gender effects can be confounded by ethnic differences in sexual behavior and psychological variables influencing condom use and sexual behavior.(14,21)

The exact number of male active duty personnel on a deployed aircraft carrier varies somewhat with the nature of the mission. Thus, assuming that 50 percent of the personnel on board an aircraft carrier are in pay grades E-4 and below, and using 30 June 1999 paygrade demographics for enlisted active duty personnel, the number of eligible male respondents is estimated to be 9,059 (2,000-2,500 eligible respondents per carrier). This large sample size is needed to understand the influence of ethnicity and acculturation on condom use, and to gain a good picture of the issues influencing condom use among these male, enlisted personnel.

Study data collection is currently in process and expected to be completed in 2004. Preliminary data analyses began in the summer of 2002 with the main study analyses taking place once the survey has been completed on all four carriers.

Summary

These survey data will be used to assess the low rate of condom usage in the military. It will also add to valuable information regarding the social, cultural, and psychological beliefs felt to be factors in condom usage. Findings from this study will clarify current beliefs concerning condoms and condom usage and the reasons that Sailors choose not to use condoms while participating in risky behavior. These findings will then be used to design effective behavioral interventions that will enhance force readi-

ness. Behavioral interventions are presently the principal means of changing high-risk behaviors and thereby controlling the spread of STDs, including HIV. Among the highest priorities for research within Navy medicine is to collect the information needed to design effective behavioral intervention programs. This study is a first step in accomplishing this goal.

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In Memoriam

It is with great sadness that the Navy Medical Department acknowledges the loss of two of its brightest and best, CAPT David M. Brown, MC, and CDR Laurel B. S. Clark, MC, on 1 February 2003. CAPT Brown and CDR Clark were among the crew of seven that manned the STS-107 orbiter *Columbia*.

Dr. David Brown was born on 16 April 1956 in Arlington, VA. He graduated from Yorktown High School in 1974, and received a BS degree in biology in 1978 from the College of William and Mary and an MD from Eastern Virginia Medical School in Norfolk, VA. He joined the Navy after serving his internship at the Medical University of South Carolina.

Upon completing flight surgeon training in 1984, he reported to Navy Branch Clinic, Adak, AK, as Director of Medical Services. He was then assigned to Carrier Airwing Fifteen which deployed aboard USS *Carl Vinson* (CVN-70) in the western Pacific. In 1988 he was the only flight surgeon to be selected for pilot training in a 10-year period, graduating number one in his class and earning his designation as a naval aviator in 1990. During his career, Dr. Brown logged over 1,700 hours in high performance military aircraft including the A-6E Intruder. In 1991 he reported to the Naval Strike Warfare Center in Fallon, NV, where he served as a Strike Leader Attack Training Syllabus Instructor and a Contingency Cell Planning Officer. Additionally, he qualified in the F-18 Hornet and deployed from Japan in 1992 aboard USS *Independence* (CV-62) flying the A-6E with VA-115. In 1995 he reported to the Naval Test Pilot School as their flight surgeon where he also flew the T-38 Talon.

Dr. Brown was selected by NASA in April 1996 and became eligible for flight assignments as a mission specialist. STS-107 was his first spaceflight. He was responsible for following experiments: European Space Agency Advanced Respiratory Monitoring System (ARMS); Combustion Module (CM-2), which included the Laminar Soot Processes (LSP), Water Mist Fire Suppression (MIST) and Structures of Flame Balls at Low Lewis-number (SOFBALL) experiments; Mediterranean Israeli Dust Experiment (MEIDEX); and the Physi-



NASA Photo

ology and Biochemistry Team (PhAB4) suite of experiments, which included Calcium Kinetics, Latent Virus Shedding, Protein Turnover, and Renal Stone Risk.

CAPT Brown was a member of the International Association of Military Flight Surgeons (past President), Associate Fellow, Aerospace Medical Association, and the Society of U.S. Naval Flight Surgeons. He held the Navy Operational Flight Surgeon of the Year award in 1986, Meritorious Service Medal, and Navy Achievement Medal. □



NASA Photo

Dr. Laurel Clark was born on 10 March 1961 in Iowa, but always considered Racine, WI, her home. She graduated from William Horlick High School in 1979, and received a BS degree in zoology from the University of Wisconsin-Madison in 1983 and an MD from the same school in 1987.

While in medical school, Clark did active duty training with the Diving Medicine Department at the Naval Experimental Diving Unit, Panama City, FL. After completing medical school, she underwent postgraduate medical education in pediatrics in 1987-1988 at NNMC Bethesda, MD. The following year, she completed Navy undersea medical officer training at the Naval Undersea Medical Institute in Groton, CT, and diving medical officer training at the Naval Diving and Salvage Training Center, Panama City, FL. She was then designated a radiation health officer and undersea medical officer and assigned as the Submarine Squadron Fourteen Medical Department Head in Holy Loch, Scotland. During that assignment she dove with Navy divers and Naval Special Warfare Unit Two SEALs and performed many medical evacuations from U.S. Navy submarines.

Two years later, Dr. Clark was designated as a naval submarine medical officer and diving medical officer. She then underwent 6 months training at the Naval Aerospace Medical Institute, Pensacola, FL, and was designated as a flight surgeon. She was subsequently assigned to MCAS Yuma, AZ, as flight surgeon for Marine Corps AV-8B Night Attack Harrier Squadron (VMA 211). She made numerous deployments, including one to the Western Pacific, practiced medicine in austere environments, and flew on multiple aircraft. She was then assigned as the Group Flight Surgeon for the Marine Aircraft Group (MAG 130).

Prior to her selection as an astronaut candidate, she served as a flight surgeon for the Naval Flight Officer advanced training squadron (VT-86) in Pensacola.

Selected by NASA in April 1996, Dr. Clark trained for 2 years before she was qualified for flight assignment as a mission specialist. From 1997 to 2000, she worked in the Astronaut Office Payloads/Habitability Branch.

STS-107 was her first spaceflight. She was responsible for the following experiments: European Space Agency (ESA) Advanced Respiratory Monitoring System (ARMS); Astroculture (AST-1 and 2); Biotechnology Demonstration System (BDS); ESA Biopack (eight experiments); Application of Physical and Biological Techniques to Study the Gravisensing and Response System of Plants: Magnetic Field Apparatus (Biotube-MFA); Closed Equilibrated Biological Aquatic System (CEBAS); Commercial ITA Biological experiments (CIBX); the Microbial Physiology Flight Experiments Team (MPFE) experiments, which include the Effects of Microgravity on Microbial Physiology and Spaceflight Effects on Fungal Growth, Metabolism and Sensitivity to Antifungal Drugs; Osteoporosis Experiment in Orbit (OSTEO); The Physiology and Biochemistry Team (PhAB4) suite of experiments, which included Calcium Kinetics, Latent Virus Shedding, Protein Turnover and Renal Stone Risk; Sleep-Wake Actigraphy and Light Exposure During Spaceflight (SLEEP); and the Vapor Compression Distillation Flight Experiment (VCD FE).

CDR Clark was a member of the Aerospace Medical Association and the Society of U.S. Naval Flight Surgeons. She held the Navy Commendation Medal (3), the National Defense Medal, and the Overseas Service Ribbon. She had been selected for promotion to the rank of Captain in May 2002. □

Book Review

The Hidden Campaign: FDR's Health and the 1944 Election by Hugh E. Evans, MD. M.E. Sharpe, Inc. Armonk, New York, 202 pages.

Hugh E. Evans has spent a decade researching the medical history of Franklin Delano Roosevelt. In his new book, *The Hidden Campaign: FDR's Health and the 1944 Election*, he attempts not only to uncover the truth behind the severity of FDR's hypertension and congestive heart failure, but also to analyze the deception of the American people at the hands of the president, his physicians, and advisors. Evans goes beyond the history of Roosevelt's battle with failing health and discusses the stress dealt with by presidents, the need for an executive branch which is not so taxing on one individual, and the shortcomings of the 25th Amendment.

The author begins with a look at the life expectancy of American presidents. Interestingly, despite technological and medical advances, the life expectancy of the first 16 chief executives was longer than those who served from the Civil War to 1980. Those presidents lived an average of 9.6 years longer!

The author also examines the length of presidents' lives compared to their parents and offspring. For the more recent presidents, lifespan is less than either their parents or children. Evans concludes, therefore, that stresses associated with the presidency are detrimental to the incumbents' health.

Evans also examines the life and health of FDR, beginning with a discussion of his childhood and early adulthood illnesses, of which he had many, including scarlet fever, typhoid fever, bronchitis, and pneumonia. There is much emphasis on FDR's contraction of poliomyelitis in 1921, a disease which caused his leg paralysis. Evans contends that Roosevelt's illness helped divert attention from his performance while he was Assistant Secretary of the Navy, thereby saving his career.

However, the author does not specifically focus on how FDR's disability affected him, but more on how his overall health influenced his ability to perform the duties of his office, particularly on the eve of his run for a fourth term. Evans states that Roosevelt's physician, VADM Ross T. McIntire, "committed deliberate errors of interpretation and omission," thereby misleading other members of the government, the press, and the American people. In March of 1944, with the war having turned in the Allies' favor, Roosevelt's health had visibly grown

worse, and Dr. McIntire consented to have a Navy cardiologist, LCDR Howard Bruenn, examine the president. FDR had been suffering from hypertension for a number of years, and Bruenn found that, along with the high blood pressure, the president was showing symptoms of congestive heart failure. Dr. Bruenn recommended bed rest, a modified diet, and the administering of digitalis to improve heart function, but was told that these measures were not possible. After all, the patient was the president, and public disclosure of his condition and or hospitalization could very well initiate public panic.

For Evans, all this raises many issues. First, McIntire and other physicians brought in as consultants decided to withhold the details of his condition from the Roosevelt family, his closest advisors, and the voting American public (although his family and advisors, at least on some level, were witnessing his deterioration in health). Likewise, FDR never asked his caregivers detailed questions, preferring instead to remain ignorant on the subject. An important issue for the author is whether, in light of FDR's poor health, would Americans, having known the truth, have voted again for a man who was unlikely to survive another 4-year term? At the time, the 25th Amendment, which more clearly delineates the line of succession and related procedures for instances when a president dies or is incompetent, did not exist.

Evans points out that the 25th Amendment is still problematic. If a president is not fit for command, it is his cabinet members—individuals who serve at his pleasure—who must vote to relieve him of his duties.

Furthermore, does the cover-up of FDR's condition suggest the need for independent medical examination of the president? Although Evan's faults McIntire, he does recognize the inherent conflict of interest for military doctors. The president is both their patient and commander-in-chief.

In *The Hidden Campaign*, Evans suggests that, "Without a shift in expectations to a more realistic plane, many presidents will by definition, 'fail' as the demands of the office continue to spiral beyond individual human capacity." This may be an issue worthy of national debate.

The Hidden Campaign is well researched, written, and highly recommended for general readers and historians alike. □

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Navy Medicine 1952



Photo from BUMED Archives

DT3 Albert Adams with Korean patient aboard USS *Haven* (AH-12), 1952.