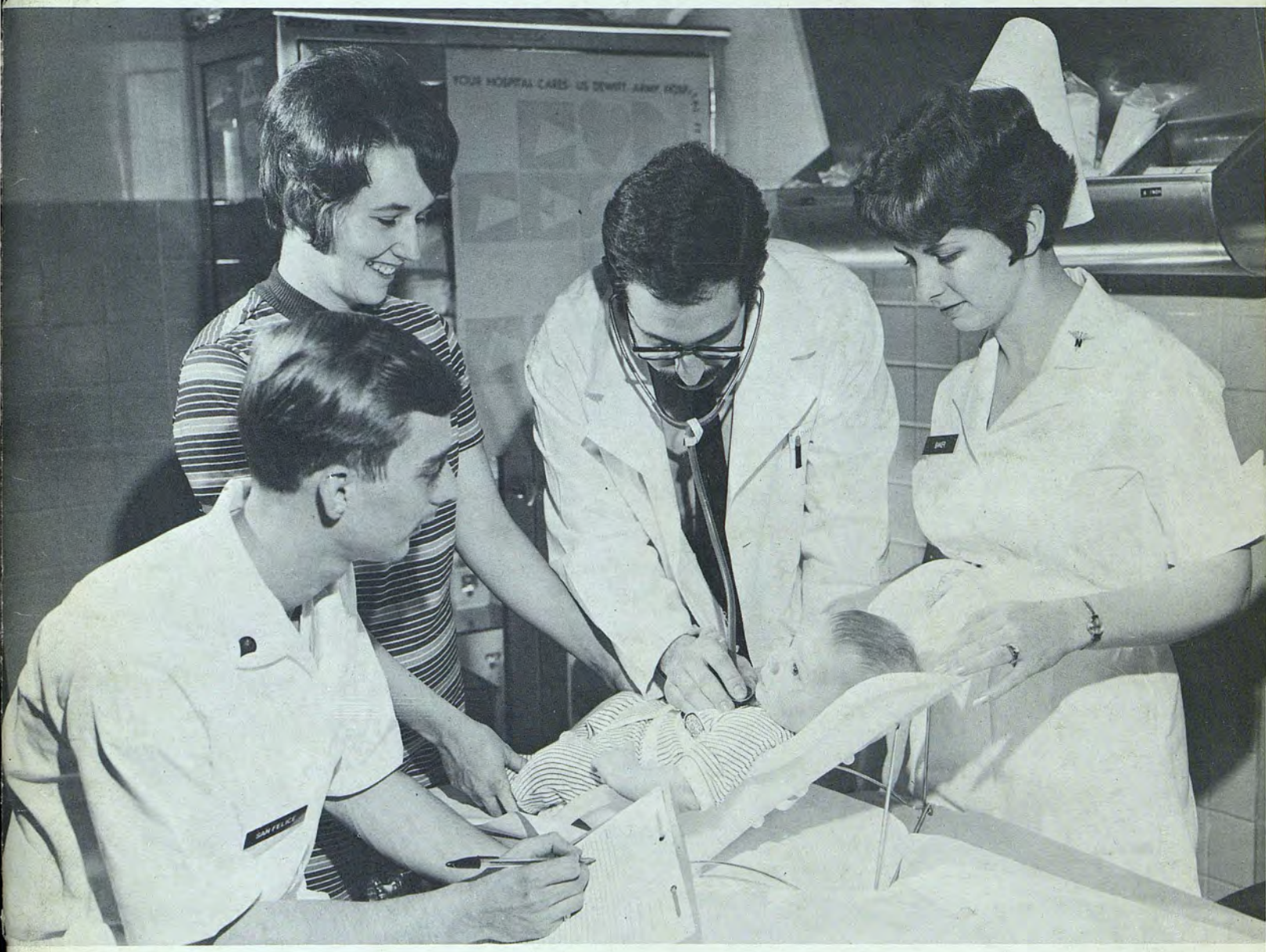
NEWSLETTER OF THE

U.S. ARMY MEDICAL DEPARTMENT



JULY 1971

VOL. 2 NO. 3

MESSAGE FROM THE SURGEON GENERAL

AMEDD:

196 Years of Support

This month marks the completion of 196 years of the Army's support by its Medical Department. Great advances have been made in preventing and treating disease and injury of the military man and his family. Of this we can be justly proud. We can be proud also of our plans for the betterment of our services to this population for whom we are responsible.

Better organization, better control of all medical resources, better management along with more efficient utilization of these resources, and better education of all members of the Medical Team are essential to future improvement. WORSAMS, a new Combat Support Hospital, the Army Physicians' Assistant Program, the new MEDDAC and Hospital Commanders Course, the new Walter Reed General Hospital prototype, and the computer-assisted Hospital Information Systems are just a few of the exciting things that are fermenting and are on the brink of becoming a reality.

A new enthusiasm is permeating our Army Medical Department that will hopefully culminate in the finest medical service ever experienced by the people we are responsible for. New standards of medical care and truly "Concerned Care" are being set by this Army team effort which, I feel, will provide the example and lead the way for all people of the United States and perhaps the world. My philosophy of MEDDAC and command prerogatives are set forth elsewhere in this issue.

The cover:

Concerned Care is a daily practice at DeWitt Army Hospital, Fort Belvoir, Va. A mother appreciates the courteous, individual attention given by members of the pediatric staff. See the pictorial feature on page 98.

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Volume 2 July 1971 Number 3

Contents

The *Newsletter of the U.S. Army Medical Department* is published by the Office of The Surgeon General, U.S. Army, on a quarterly basis. This publication is intended to develop a greater unity and understanding among Army Medical Department personnel and to serve as a medium for dissemination of timely information not normally and readily available in other media published by the U.S. Army.

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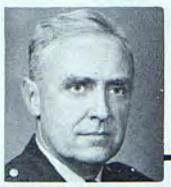


Medical Corps

BG Thomas J. Whelan, Jr., MC
Special Ass't for Medical Corps Affairs

I would like to share with you the comments that I presented last January before the Los Angeles Surgical Society. The title was "The Interdependence of Military and Civilian Surgery":

Surgery and war have always been inter-linked. Sir Thomas Clifford Albutt stated it this way: "I would remind you again how large and various was the experience of the battlefield and how fertile the blood of warriors in rearing good surgeons."

The beginnings of modern surgery arose out of the care of the wounds resultant from military experience. Sir Heneage Ogilvie states: "During the wars that swept Europe throughout the dark and middle ages, wars of rebellion and wars of succession conducted for the most part by professional armies, wars that flared up and died down, separated by uneasy truces but never by lasting peace, surgeons learned their work with the armies. The only men whose names have come to us, the men who thought rather than copied and who added to the knowledge of their time, men like Henri de Mondeville, Guy de Chauliac, John Arderne, Ambroise Paré and Richard Wiseman, served with the armies of their countries; and when they came back from campaigning, with their unrivalled experience and with the patronage of the kings and princes whom they had accompanied to war, they became the leading surgeons in civilian practice, the surgeons to the hospitals, the teachers of the next generation."

Planned operations for the treatment of disease is a late 19th century-20th century arrival; Reginald Fitz's classical article on appendicitis written in 1886; the first ovariotomy in 1809; cholecystectomy did not become standardized until the late 19th century despite the first recorded case being 1743. The surgical treatment of hernia antedates all of these efforts but had no scientific basis for repair until the timeframe already defined.

Advances in Non-Military Surgery

With the stage for modern surgery set with the important props of anesthesia, developed in the first half of the 19th century and antisepsis and asepsis during the latter half, the curtain rose upon a setting which nurtured the rapid advances in non-military surgery. Operations for cancer of breast, bowel and stomach were perfected as were operations for the treatment of non-malignant disease. The older anatomic basis for surgery was supplanted in the first half of the 20th century by the physiologic basis.

The physiological basis of body fluid homeotasis, of shock, of gastrointestinal and cardiopulmonary systems were and are still being studied by increasingly sophisticated means and at a more basic cellular and molecular level. Each of these advances has had an effect upon military surgery since advances are made in military surgery only within the state of the art within the general scientific community at a certain point of time. Vascular repairs were not feasible until the field of vascular surgery matured. This maturation was dependent upon improvements in instrumentation, suture materials, and ready availability of blood. Conversely, the maturation of vascular surgery in the civilian setting was dependent upon the advances in the military of blood-banking techniques developed during World War II.

The development of closed cardiac surgery, surgery upon the degenerative disease of peripheral vessels and finally open heart surgery were developed within a 15-year period, from 1945 to 1960. It is no wonder that with this interest and with individuals prepared to tackle these problems, the 81 repaired vascular cases reported by DeBakey and Simeone in World War II expanded to 315 cases in the Korean War and to over 10,000 cases repaired

so far in the Vietnam Conflict. The story of the interdependence of the civilian surgical community and the military surgical community in vascular surgery is not an isolated example.

Three main areas of interdependence will be used to develop the theme: (1) The interdependence in post-doctoral graduate medical educational programs; (2) The interdependence in the development of innovations in health care delivery systems; and (3) The interdependence in the development of optimal care of the traumatized patient.

First Army Internship

In 1920 the Army initiated its internship. From a total of five interns at Walter Reed General Hospital and one at Station Hospital, Fort Sam Houston, the number of interns, both straight and rotating, has increased to 191 in seven Army teaching general hospitals. The Army Residency Program initiated in 1948 has now burgeoned to 85 separate programs with 815 residents in these same seven teaching hospitals. In addition, 53 physicians are receiving fellowship training in civilian institutions. All of these training programs are conducted under the same monitorship and review as are civilian graduate medical training programs.

There are three aspects of Army graduate medical education programs which distinguish them and enumeration of these points will immediately suggest areas for conscious interdependence of your programs and ours. All of our patients, our clinical material, are "ward" type patients. All are available for intern and resident training. We, therefore, are one of the last strongholds of the old residency system in the Halstead tradition. Secondly, our staffs are 100 percent full-time and omnipresent.

The men who make up our academic staffs have no other commitment than that commitment to patient care on their service and to the teaching of interns and residents. Thirdly, at the present time, graduate medical training is now diluted with increasingly large numbers of medical students. This is not to say that we should not do more in the education of students during the clinical years of medical school, for I feel we have vast material untapped by medical students. Our entire class I system, our station hospitals, has not been exploited. At present, we teach obstetrics to University of New Mexico students at the Sandia Base Hospital; internal medicine, dermatology and pediatrics to Medical College of Georgia students at Fort Gordon and over 220 clinical clerks per year are taught in all of our teaching hospitals. With the university being asked to admit more medical students and with clinical material increasingly more inaccessible, it seems a "natural" that we accept students on a regular prearranged rotation—particularly in our station hospital system.

Station Hospital Training

There are three reasons for the selection of the station hospitals: (1) The student will get more individual attention for large numbers of interns and residents are not simultaneously being taught; (2) Our medical staffs will be stimulated to teach; and (3) The class II or teaching system is glutted in terms of space and staff-student ratio. The weaknesses of our programs center upon former unrealistic staffing ratios which are being improved slowly. The Army manpower experts have only recently recognized that staffing for teaching services cannot be calculated on parameters measuring only delivery of health care. While there was one, and at most, two surgeons running a training program in general and vascular surgery in 1960 at Walter Reed General Hospital, there now are five such individuals. All these surgeons are Board-certified and several are contributing actively to the national and international medical scene.

Another weakness is the absence of the university environment and the relative non-availability of research opportunities. This weakness is being strengthened as we develop a small group of research-oriented surgeons. We have four young Board-certified surgeons in a research training fellowship at Walter Reed Institute of Research. We have, in addition, two additional career surgeons, one at Duke and one at University of Connecticut, in three-year educational programs in quest of PhD's in the basic sciences. We have established clinical research services in each of the teaching hospitals and will assign these men to these services with free interchange and responsibilities within the Department of Surgery so that they may continue to be active in teaching and patient care.

We all know that a teaching program must stimulate within the student a desire, a drive to explore. In providing this type of environment we also provide a better quality environment for patient care.

World Is Campus

Finally, the world is the campus for the Army graduate medical education programs. Until last year we had not taken advantage of this factor. This year we began three-month rotations for chosen pediatric residents to the Childrens' Hospital in Bangkok, Thailand, to study diseases they would never otherwise have seen. In the next month or two, I am to visit Malaysia and will assess the value to our Infectious Disease Fellowships of a rotation through our laboratory in Kuala Lumpur. These opportunities are unique to our programs and we seek to increase these opportunities.

Let me remind you that we are anxious to contribute to teaching of medical students and to candidates in civilian internship and residency training programs. You have contributed to filling out some of our teaching programs—pediatric orthopedic surgery, neonatology, reproductive endocrinology, to name only a few. I believe we can help you. The American Academy of Orthopedics is actively planning regionalized orthopedic programs but in this concept the residency would be an integrated one with the choice of residents made by the University controlling the particular region. This arrangement we could not accept for

two pertinent reasons: (1) We must remain autonomous in order to be responsive to the Army in its prime role of guarding the national security and (2) our resident program represents essentially the *sole* source of career medical officers despite a low eventual retention rate of 10 per cent. Although we in the Army hate to lose a young man who has all the "tickets" and talents, we must remember we are U.S. citizens and that whether we wear the uniform or not, the development and molding of an outstanding physician is our real task.

Retention

In the past three years we have retired 75 Army physicians who have stepped into important academic positions. The most important mission which I have in my new job is the creation of a professional environment and other incentives which will attract and retain talented physicians. As our educational programs go, so will go the future of the uniformed Army Medical Corps. We have increased our base in terms of programs and numbers. The applications have increased from 280 in 1968 to 560 in 1969, to over 600 in 1970 for 275 first-year positions in 85 programs. My problem is to retain an outstanding faculty. Toward this end, I have made a total commitment to stabilization of tours and increasing tenure of academic positions. Lack of tenure has frequently been mentioned by Residency Review Committees as criticism of our programs. Rightly so. The only reasons for moving a member of our senior teaching staffs now are: (1) failure to do the job or (2) the individual's desire to move.

In the past year I had to make a painful, yet, I trust, fair decision. With continuing hostilities in Southeast Asia, with almost all career medical officers having served one tour (except for the teaching staffs), we initiated a program whereby the teaching chief of an Army program, when indicated, took a one-year tour in Vietnam or Korea, returning to his original post at the conclusion of the tour. His assistant filled in during that year obtaining help from a more junior, fully-trained physician. The return of the chief a year later created minimal personnel turbulence and the one-year tenure of the assistant contributed much to his own professional maturation.

If our educational problems fail and our career corps is decimated, our ability to give care to more than 3.7 million active duty soldiers, their dependents and retired persons and their dependents, will not exist. The end result will be an overwhelming saturation of already-strained medical facilities of the civilian community as this case load is transferred to the civilian community through OCHAMPUS.

Contract Surgeons?

A partial alternative might be the use of contract surgeons in Army hospitals. This alternative would create a professional staff which is non-responsive to the mission of the Army —an unacceptable alternative.

The second area of interdependence is in the development of health care systems. Because of tighter organizational control and a more rigidly structuralized society within the Army I submit that we can act as the laboratory for research in developing better systems. In Europe the development over the past 12 years of the Army Medical Service Area concept has allowed maximal pooling of resources within each area for better patient care. The medical command in Europe controls each hospital, which in turn acts as the nucleus and headquarters for all other medical care facilities within its geographical area—dispensaries, clinics, veterinary detachments, dental clinics, etc. This arrangement allows for pooling of administrative, operational and fiscal functions within the one headquarters and gives cohesiveness to the area which allows moves of personnel and supplies to points of need within the service area.

Plans and execution of medical evacuation procedures are coordinated in the area headquarters. Each of the medical care facilities is fitted into the whole by virtue of its function. Because of vested interests and lack of an overall control, each civilian community tends to duplicate equipment and other resources. Such an arrangement contributes to rising costs of medical care. It might be worthwhile to have civilian medical planners look at this system which has been in operation for over a decade.

WORSAMS

On a larger scale, the Army Medical Department is so pleased with the working of the medical service area and so convinced that control and management of resources is essential to economical and efficient delivery of health care that, following a one-year study, a *Worldwide Organization Structure of Army Medical Services* has been presented to the Army staff.

Under this plan all health services for the Army would be administered through a Health Services Command, whose commander would be The Surgeon General, through four regional commands in the United States, and through a Pacific and European Command. Each of these regional commands would have one or two major hospitals or medical centers assigned to it under whose control will come the smaller hospitals in the region. This arrangement will give The Surgeon General control of all his resources which he does not now have. He has at present no control over the station hospitals, these facilities being commanded by the post commander upon which they reside and ultimately under the commander-in-chief of the Continental Army Command, the Pacific Command or the European Command.

The development of *intensive care units* was originally an outgrowth of Army studies to concentrate nursing and medical personnel where the intensity of care was greatest. The attempt was made to save on scarce personnel. The plan served another most important service and that was to transfer the nurse from desk back to bedside. Although early planning was performed in the Army, the civil-

ian community picked up the concept, liked it, developed it, and outstripped us. It has been only recent that we have been catching up.

Progressive Patient Care

For years the Army Medical Department, as well as other military services, has used *progressive patient care.* Two main factors dictated its early use in military hospitals. Firstly, the active duty patient cannot be discharged from the hospital until he is able to perform duty. His hospital stay is, therefore, longer than in a civilian hospital, the result being a greater proportion of not-so-ill patients convalescing from disease or operation. Secondly, because of shortages of clerical personnel, clerks, messengers, etc., the convalescing patient is used as a part-time helper, as dictated by his physician, alleviating the shortages and occupying his long hospital tours. In the Army the ambulatory care facility of the civilian community is called the medical holding detachment. Here the convalescent lives in a self-care environment returning to his active treatment ward, as scheduled, for dressing changes, other treatments or evaluation. In this area also, although the concept began in the military medical environment, the civilian medical community has begun to implement this concept and, I believe, has taken the concept one step beyond the ambulatory care facility.

In yet another area in the health care field the civilian community has seen, studied and is actively developing a military medical concept—the paramedical corpsmen who is undergoing a metamorphosis in the civilian community to a physician's assistant. Many of you who have been with the military medical department in the past will remember, with admiration, the ability of the medical corpsman. It will also come as no surprise that the career ladder for these individuals has a closed end in the military, leading to the large numbers who opt to leave the military (estimated at 30,000 per year from all services).

Because of shortages of general duty medical officers, because of a required replacement of physicians in the combat maneuver battalions, because of ever-increasing specialization, because of ever-increasing outpatient loads in all of our hospitals and because of a need to give our corpsman an attractive career in the military we have just begun the development of the Physician's assistant in the Army.

Air Evacuation System

Finally, I must dwell for a minute or two upon the great advances made in the *medical Air Evacuation system* by the Army. In order to make the system function, concomitant regulation of casualties and sorting procedures are necessities. To have a rapid means of transportation, such as the helicopter, and no plans within a region or within a hospital for handling large numbers of badly injured individuals is to denigrate the efficacy of the helicopter and to fault the entire system. The helicopter in the combat environment is merely a means of transportation; in that situation the injured man has had his wounds dressed, hemorrhage stopped, airway established and may even have fluids running, these measures performed by medics or battalion surgeons prior to being placed in the helicopter.

In the civilian setting the helicopter may, of necessity, have to become additionally a small intensive care unit. The early arrival of casualties in the Vietnam conflict has introduced new problems for combat surgeons. Time lags of 10 hours in World War II have been reduced to four hours in the Korean War and to two hours in the Vietnam Conflict. Patients who would not have arrived at hospitals in other wars do arrive for treatment in this one. The use of a multiple team approach, aggressive resuscitation, which more often requires operation as an integral part of resuscitation, massive transfusions, early airway control with endotracheal tubes, use of ventilators, central venous catheters, monitoring with pH and blood gas analyses have become prevalent in order to salvage mortally wounded men.

Several civilian communities are experimenting with helicopter evacuation. It should be emphasized that intra-city medical regulation of casualties so as not to inundate one hospital must accompany air evacuation and all emergency rooms should be readied for arrival of more seriously injured individuals.

The final area of interdependence is the professional area. I shall not address advances in fields other than surgery but I am sure this audience is aware of the many advances in preventive medicine, in military psychiatry, and in renology and infectious and tropical disease in the military service.

At the beginning of any campaign many old lessons are relearned. This lag period during which old mistakes are made has been shorter in the Vietnam conflict than in other wars. The reasons for this include (1) a moderately large number of career surgeons who had already relearned old lessons in the Korean war and (2) the practice of placing new combat surgeons with older, more experienced hands.

Blood Banking

Blood-banking procedures were initiated during World War II and were perfected between the wars. In Korea high- or lower-titer O blood was used and type-specified blood was not. Hyperbilirubinema occurred in 25 per cent. In Vietnam, type specified blood has been used unless low-titer O blood has been started, in which case, if four or more units have been given, low-titer O blood is continued.

The blood program in Vietnam has provided blood in large and plentiful amounts at all times. Since 1967 the majority of blood for Vietnam has been drawn in the U.S. Resuscitation procedures have been influenced by advances in techniques developed by civilian surgeons. The difference in resuscitation procedures as practiced in World War II, the Korean War, and the Vietnam conflict reflect this fact. A severely wounded individual will have an endotracheal tube inserted

and will have air or oxygen administered under pressure first from an Ambu bag and shortly from a volume-controlled ventilator. An arterial blood sample will be taken for pH, pO2, and pC02; a central venous catheter through a percutaneous subclavian vein approach will be placed for administration of large volumes of blood.

Early in the campaign large amounts of Ringer lactate were administered, influenced by contemporary studies during 1965 to 1968. Fluid overload resulted from overzealous use of this fluid and exacerbated problems of wet lung. Central venous pressure was a poor indicator of this overload since diffusion of balanced salt solutions to all body fluid compartments caused only late changes in the central venous pressure. As soon as blood gas analyses were possible in Vietnam in 1967, early mistakes in giving Empiric sodium bicarbonate were corrected. Many patients were actually alkalotic upon arrival in hospital from the hyperventilation of pain and anxiety; only the patient in deep and prolonged shock was acidotic. Even in these latter patients sodium bicarbonate only helped temporarily by neutralizing lacticacidemia. Improvement of tissue perfusion by replacement of blood volume proved to be the only permanent measure.

In this war operation for the control of hemorrhage as a vital part of resuscitation has been practiced much more frequently than in other wars. The reason for this modification of approach has been the early arrival of severely injured patients at the hospital.

Most of the wounded will, however, as before, benefit from stabilization of vital signs and establishment of a urinary output prior to an operation.

In the postoperative period if intestinal obstruction occurs due to multiple intra-abdominal abcesses, surgeons, who had used them and could obtain them, utilized the Baker tube successfully to decompress the boggy loops of inflamed bowel and to allow better positioning of the bowel within the abdomen—a fortunate and timely civilian contribution.

Unsuspected Hypoxemia

Many observations upon arterial pO2 values pre-flight and during flight of patients with major fractures as well as belly and chest wounds, have suggested frequent occurrence of unsuspected hypoxemia. At cabin altitude equivalents of the jet medical evacuation planes these levels become extremely dangerous. There seems little question that a pO2 is the most important parameter to measure prior to air evacuation.

In the treatment of specific wounds, I shall select those portraying the greatest degree of interaction of civilian and military medical thinking.

First, liver wounds seen in this war are much more similar to civilian blunt trauma wounds than liver wounds seen in other wars. The destructive potential of missiles traveling at velocities of 3200 and 4000 feet per second produce such shattering wounds, and the patient in many instances arrive alive at the hospital because of rapid evacuation. In contrast, in World War II 91 per cent of liver wounds were not bleeding at operation and some British surgeons advised against laporotomy if the diagnosis of isolated liver wound was made. With the increase in severe wounds of the liver, techniques for lobar resection have been used more frequently to control hemorrhage and remove dead and damaged tissue. Techniques used for elective hepatic resections — hypothermia, thoraco-abdominal incision, total hepatic inflow occlusion, blunt dissection through the liver tissue, and individual ligation of ducts and vessels —all are available to the military surgeon faced with the shattered liver. Adequate drainage of the perihepatic spaces learned during World War II, and drainage of the common duct, learned from civilian surgeons, continue to be used, the former in all cases of liver wounds, the latter in major liver lacerations particularly if resectional therapy has been necessary.

Right Colon Wounds

Right colon wounds have always proven an enigma and opinions have been divided as to their proper handling. The tendency to suture or anastomose large bowel in civilian injury must be avoided in the military situation. The inability for one surgeon to see the case to final outcome militates toward the conservatism of Sir Heneage Ogilvie who first in the East Africa campaign in World War II insisted upon and standardized exteriorization of the wounded bowel or defunctionalizing proximal colostomy with suture and/or drainage of the wounded distal bowel.

Exeriorization of the right colon, however, led to a large bulgy colostomy which constantly poured forth liquid, alvine ileal contents. In Vietnam an exception was made to exteriorization of this portion of the bowel and primary anastomosis was allowed. However, particularly when contingous organs were injured—duodenum, liver, kidney—or when there was extensive muscle damage in the retroperitoneum, there was a significant breakdown of these anastomoses.

At the 4th CINCPAC Surgeon's Conference in Tokyo last year, there was increased emphasis on a mature end-ileostomy, resection of damaged right colon, and musous fistula of the distal right colon or transverse colon. Results evaluated in Japan showed 47 per cent complication rate of all right colon wounds and 9 per cent anastomotic leak when the right colon was anastomosed.

In vascular wounds techniques for suturing vessels were freely borrowed from civilian sources. As far back as World War I German surgeons performed arteriorraphy after the methods which Guthrie and Carrell described in the United States prior to World War I. There was little attempt to repair vessels during World War II and during the first two years of the Korean War.

Vietnam Medical Facts

However, the field of vascular surgery had begun to blossom so that by

1952 the repair of acutely injured arteries was taken to the front-line hospital. Success was immediate with an over-all reduction of amputation rate from 40 per cent with ligation in World War II to 13 per cent with vessel repair. Between 1954 and 1965 many surgeons were trained in vascular surgery techniques in resecting abdominal aneurysms and bypassing segmental occlusive disease caused by atherosclerosis so that when large numbers of surgeons began to be assigned to Vietnam the stage was set for the repair of thousands of arteries. After five years of Vietnam experience we can now feed back to civilian surgery the following facts:

(1) The amputation rate continues at 13 per cent.

(2) Popliteal artery injuries are still the most discouraging and still carry a 32-38 per cent amputation rate after repair.

(3) In most cases of popliteal artery repair, particularly with concomitant popliteal vein injury, prophylactic fasciotomy is mandatory.

(4) Accompanying veins should be repaired whenever possible.

(5) When soft tissue and bony damage are severe distal to the arterial injury, immediate amputation is the procedure of choice. This is a difficult judgment decision which will save life while sacrificing limb.

(6) Intraoperative angiography should be used whenever distal pulses do not appear immediately. There is probably trouble downstream.

(7) Although spasm may occur, spasm is usually spelled C-L-O-T.

(8) Two-thirds of the patients do very well after an arterial repair but one-third develop complications. These complications are, most frequently, thrombosis, or secondary hemorrhage, usually in the presence of an infected or a contaminated wound, or false aneurysms and arteriovenous fistulae.

(9) Arteriovenous fistula always occur in an overlooked arterial wound.

(10) Secondary hemorrhage from a critical major vessel repair in the presence of an infected wound will require proximal and distal ligation of the bleeding vessel plus extra-anatomic bypass through uninfected tissue.

In the case of major joints two words of caution have come out of the Vietnam conflict. First, following debridement of the joint, the synovial closure should be loose enough to allow for escape of the effusion which always develops. Since the cartilage is not exposed there is no chondritis associated with loose closure of the synovium. Topical antibiotics have been used in various ways. Regardless of the method, an assumption must be made that the entire dose instilled into the joint may be absorbed systemically. Tragedies with four patients in different hospitals prompt this warning. These patients were receiving neomycin-bacitricin-polymyxin B topical antibiotics. The topical dose was larger than the accepted systemic dose and all of these patients became deaf; two developed renal failure, one of whom died.

I have attempted to show wherein we depend upon each other in many areas of our profession. I am greatly disturbed concerning over-publicized schism between the military and the intellectual segment of our society. Such a schism allowed to develop more widely is not good for society. The military surgeon straddles this schism. If by this presentation this evening I have been able to draw us a little closer together by discussing wherein we have been able to help each other in the past and wherein we may help each other in the future I shall have accomplished much for each of us. Interdependence of military and civilian surgeons will continue only through mutual respect.

Deadline for Residency Applications

Interested Medical Corps officers are reminded that the deadline for receipt of completed residency applications at the Office of The Surgeon General is 1 November. Inquires and applications may be addressed to the Office of The Surgeon General, ATTN: MED-MC-MT, Washington, D.C. 20314.

Residency Starting Date

The Surgeon General decided on 8 October 1970 to change the starting date of all residency and fellowship programs to 1 July beginning in 1971. This change from our previous 1 September starting date is to make our program coincide with most of the other graduate medical education programs in the country. An additional benefit is that our medical officers will be able to move earlier in the summer which will facilitate school placement for children and put our families in a more competitive position for obtaining housing.

To permit interns finishing on 30 June travel and leave time, and because civilians can not be brought on active duty until 1 July with authorized travel subsequent to that date new residents have been ordered to report not later than 15 July. For the purpose of calculating service obligation for training, residencies and fellowships starting in 1971 will be considered as terminating 30 June of the last year of training.

Officers who have received residency agreements with the service obligation based on a 14 July termination date will have their service obligation recomputed based on a 30 June termination date. No action on the part of the officers concerned is necessary and revised residency agreements will not be issued.

Funds for Conference Travel

Attendance at professional conferences is essential for Medical Corps officers to keep abreast of modern developments; learn new techniques in their professional fields; and, supplemented with short-course training, enhance their professional career development.

The Surgeon General has stated on many occasions that all AMEDD personnel will be afforded the opportunity to attend one conference per year regardless of length of service subject to the availability of funds, the number of personnel available for duty, and the benefit to be derived from attendance at such conferences. All personnel are encouraged to attend confer-

ences of a regional, sectional, or national nature, rather than state or local meetings.

Funding for conferences is a responsibility of local installation commanders. The Special Assistant for Medical Corps Affairs receives very limited funds that may be used to pay for essential conference travel which cannot be funded locally. The number of requests submitted to this office, however, far exceeded the money available for this purpose during FY 1971. It is anticipated that funds for FY 1972 also will be severely restricted.

Accordingly, local commanders should forward only those applications for which they cannot fund and which involve the presentation of a paper at a national professional meeting, the officer is being accepted as a fellow in a national professional society; or the local commander believes there is some urgent reason for attendance.

Routine requests for funding by this office must, of necessity, be returned without action.

In Thailand:

BG Whelan Observes Residency Rotation

General Whelan recently visited the Bangkok Children's Hospital, Bangkok, Thailand, to observe the new resident rotation in infectious disease for selected senior pediatric residents from the Army Pediatric Residency Program.

CPT Robert B. Shearin, Walter Reed General Hospital, was the first participant and CPTS Lawrence Crowley, Tripler General Hospital, and Lyndon Mansfield, Brooke General Hospital, the second and third selectees.. All agree the rotation represented the highlight of their training program and highly recommended it to their fellow residents.

On unaccompanied tour of three months, the residents stay in the Chao Phya Hotal in Bangkok and in additon to clinical experience with diseases uncommonly seen in this country are offered seminar-type experiences in microbiology, epidemiology and other facets of infectious disease.

Selections for the training year 1971-72 have been made and the program is full with eight participants eagerly anticipating their stay in Bangkok.

BG WHELAN VISITS THAILAND: *Top:* At the bedside of a young patient in Bangkok Children's Hospital are (*l to r*): COL Altstatt, Director of the USA Comp SEATO Labs; BG Whelan, and CPT Lyndon Mansfield, Brooke General Hospital resident. *Bottom:* Between wards are (*l to r*): CPT Lawrence Crowley, Tripler General Hospital resident; Dr. Paythai, Medical Director of the hospital; COL O'Neil Barrett, Chief, Department of Medicine Chief at Tripler; BG Whelan; COL Altstatt, and CPT Mansfield.

Dental Corps

MG Robert B. Shira, DC
Ass't for Dental Services

Changes in Residency Programs

For some time the Council on Dental Education and the specialty boards have been critical of our residency programs in oral surgery, periodontia and endodontia. Each of these specialties requires training in basic sciences. Since 1962 we have provided this training in the Advanced Theory and Science of Dental Practice course conducted at the U.S. Army Institute of Dental Research (USAIDR). Following this course, the students are sent to various installations to receive the clinical portion of their training.

The council and the specialty boards feel that a fully integrated program conducted at one institution is preferable to the divided programs we are now providing. They desire a program that provides for progressive, sequential training, with gradually increasing responsibilities for the residents.

The American Board of Oral Surgery has become quite insistent that this change be made. Consequently, in 1971 there will be no oral surgery input into the Advanced Theory and Science of Dental Practice course at USAIDR. Instead, the oral surgery trainee will be assigned directly to a general hospital and will receive his entire training at that installation.

This change will throw an additional burden on the oral surgery staffs at the training hospitals for they will have to integrate basic science teaching throughout the three-year program. Since our teaching hospitals are also conducting training in many of the medical and surgical specialties, it is felt that coverage in the basic sciences is available and adequate training can be provided.

The Mentors of the Oral Surgery Training Program, at their January 1971 conference, strongly favored immediate implementation of this program. Hence, in the future, the oral surgery training will be provided at Brooke, Fitzsimons, Letterman, Madigan, Tripler, Walter Reed and William Beaumont General Hospitals. The program at Fort Bragg will be discontinued. Oral surgery is the only residency conducted at Fort Bragg. Since there are no training programs in the medical and surgical specialties at this installation, it was felt it would be extremely difficult for the oral surgery staff to provide the necessary coverage of the basic sciences.

It is our current feeling that similar changes in our periodontia and endodontia residencies will soon be implemented. A recent letter from the American Board of Periodontology stated: "The Board confirmed its position in favoring integrated programs given within one institution." They are encouraging us to discontinue our split programs and seek approval by the Council on Dental Education of integrated two-year programs conducted at one installation. We feel it is but a matter of time until a similar request will come from the American Board of Endodontia.

Continuation Pay

I feel every dental officer should be kept up to date on the status of P.L. 90-207 and P.L. 90-228 as they affect our corps. As you know, this is the legislation authorizing continuation pay and relief from limitations of promotions for Medical and Dental officers. The laws were passed in 1967 and have been implemented for medical officers but not for dental officers.

In previous issues of the *Newsletter* I have explained that additional information establishing need for extending the benefits of this legislation to dental officers was forwarded to the Department of Defense by the three services in the fall of 1970. The House of Delegates of the American Dental Association, at the 1970 Annual Session, passed resolutions urging the Department of Defense to implement the legislation for dental officers.

The House further directed that Dr. John Deines, association president, seek a personal interview with the Secretary of Defense to explain the con-

cern of the dental profession over the discrepancy that exists between medical and dental officers. A letter was written to Mr. Laird, but due to his extremely busy schedule, he was unable to see Dr. Deines. However, in March, he did see Hal Christensen, in charge of the Washington office of the American Dental Association. Mr. Laird assured Christensen that he was aware of the problem and that it would receive the personal attention of his staff.

On 8 April 1971, Mr. Laird wrote the following letter to the President of the American Dental Association:

Dear Doctor Deines:

For some time now I have been wanting to write you in regard to our mutual concern for the well-being of the dental corps of the uniformed services. My recent meeting with Hal Christensen has re-enforced my concern.

We are both aware of the manifold problems facing the dental corps and the evidence of deteriorating morale among our dental officers. We are aware that too few of the highly promising young men who enter choose to remain for a career. We are aware that too many officers of rank and experience feel it necessary to resign or voluntarily retire, often at just that point in their careers when their federally financed training is coming to full fruition.

I want to assure you that this matter has the personal attention of my staff as well as that of the Assistant Secretary for Health and Environment, Dr. Louis M. Rousselot.

I know your Association believes strongly that implementation of the existing authority to extend continuation pay and special promotion opportunities to dental officers would relieve the problem. I want to be certain, however, that whatever action we take will move us in the proper direction and believe that we must take the time to review all possible alternatives.

In addition, as you know from the history of P.L. 90-207 and P.L. 90-228, there is a problem involving the legislative branch of our government that will need to be resolved. It is my intention to review this entire situation immediately and to determine the interim actions that appear to be warranted. I assure you that your Association will be consulted and advised by my office before final action is taken.

I hope that you will, through this letter, remember me to my many friends in dentistry. I hope you will tell them of the warm memories I have of our past cooperation and the confidence I share with you that such cooperation continues now and will continue in the future. I am most regretful that the press of current duties made a personal visit impossible but, in lieu of that, my conversation with Hal was most useful and informative.

Sincerely,

/s/ Melvin R. Laird

Dr. John M. Deines
President, American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

This is where the matter now stands. The problem involving the legislative branch of the government mentioned in Mr. Laird's letter undoubtedly is the 1967 statement of the Armed Forces Committee which stated that: "While the Committee accepts the inclusion of Dental officers as provided in the House version of the bill, it does so with the clear understanding that (1) there is no need at present to extend the continuation pay to Dentists, (2) the Department will not so extend it in its implementation of the program and (3), the Department will not extend the program to dentists in the future under present conditions. A review of the dental officer situation might be justified in the future if their retention problem changes drastically and deteriorates to a point comparable to the present medical officer situation."

This probably means that implementation of the legislation for dental officers depends upon a change in position by the Senate Armed Forces Committee.

I assure you that I am following every conceivable approach to have our officers included in this legislation. I welcome your suggestions of other approaches and will follow through on any that are feasible. I encourage each of you to exert any influence you may have on the Congress to have dental officers receive the benefits of P.L. 90-207 and P.L. 90-228.

Training of Canadian Dental Officers

For some time we have been accepting one Canadian dental officer each year for training in periodontia. The officer attends the Advanced Theory and Science of Dental Practice at USAIDR for one year and then spends an additional year in clinical training at Walter Reed General Hospital.

The Chief of the Royal Canadian Dental Corps has requested that we discontinue the training in periodontia and initiate a training program in oral surgery. Consequently, two officers, MAJ F. H. Harreman and MAJ J. D. McCallum, will begin their training in July. Major Harreman will be assigned to Letterman General Hospital and Major McCallum to Madigan General Hospital. They will receive the three-year integrated training program conducted at one institution, as described above.

1971-1972 Intern Program

Additional training spaces have been authorized for the Army Intern Training Program. Sixty-eight interns will begin training in July at the following installations:

William Beaumont General Hospital	4
Brooke General Hospital	8
Letterman General Hospital	8
Madigan General Hospital	4
US Army Tripler General Hospital	4
Walter Reed General Hospital	4
Fort Bragg	8
Fort Benning	4
Fort Jackson	8
Fort Sill	8
Fort Leonard Wood	8

We received many applications for these 68 positions and are assured an outstanding class. Many of those selected were among the leaders of their respective classes. It is significant that we had only seven declinations, which attests to the fine reputation our program has developed in the dental profession. These spaces were filled by alternates. We look to this group for our future leaders; so I urge all who are involved in this important program to work diligently to make the programs a meaningful learning experience for the trainees.

Draft of Dentists

I am sure you are all aware of the FY 1972 Draft Call for physicians and dentists. For the first time since 1966, we failed to obtain a sufficient number of volunteers to meet our requirements. Therefore, the Department of Defense requested the Director of Selective Service to draft 536 dentists—440 for the Army and 96 for the Navy. The Air Force was able to satisfy its requirements with volunteers.

Our requirements called for the fol-

lowing input:

July	216
August	112
September	86
October	26
Total	440

The draft call was issued in March. Our largest requirements were for July and August, and Selective Service issued notices of induction to the 1969 and 1970 dental graduates, since the 1971 seniors would not be eligible until after graduation from dental school. The law requires that dentists be given 90 to 120 days after receiving notice to comply.

When the induction notices were distributed, our office was inundated with calls protesting the action. Apparently, the Department of Defense, Congress, and the American Dental Association were similarly involved. Obviously, many dentists in the 1969 and 1970 classes had requested duty with the Armed Forces when they graduated but were denied the opportunity to serve because of lack of vacancies.

Dentists in training programs, as well as those who had already established their private practices or who held teaching positions on dental faculties, were receiving induction notices. Because of the disruption of these dentists, considerable pressure was exerted and, on 12 April 1971, Selective Service cancelled the dentist draft. This action had my full concurrence for I felt it was unfair to draft the 1969 and 1970 dentists. I also felt we could probably meet our requirements by other means.

Upon cancellation of the draft, I immediately wrote the deans of all the dental schools, urging them to encourage the 1971 graduates to volunteer for duty with the Army. The response to this request has been most gratifying. In additon, the 1969 and 1970 graduates who received induction notices were contacted and given the opportunity to come on active duty if they so desired. Several have indicated a desire to serve. It is now felt that our requirements will be met from these sources. If not, Selective Service will be requested to issue a draft call after 1 July 1971 to make up the deficit. It is felt that, if this draft is necessary, it will involve the 1971 graduates.

In the 19 April 1971 issue of the *ADA Leadership Bulletin* and in the 26 April 1971 issue of the *ADA News,* the association stated: "The ADA Council on Federal Dental Services and the Washington office were highly instrumental in influencing the decison (to cancel the draft)."

The following is a quote from a letter I wrote the American Dental Association following the cancellation of the draft.

John M. Deines, D.D.S.
President
American Dental Association
227 Broadway East
Seattle, Washington 98102
Dear Doctor Deines:

I wish to extend my congratulations and thanks to the Association, and especially to the Council on Federal Dental Services and the Washington office for acting so effectively in helping bring about the recent cancellation of the draft call for 440 dentists. We in the Army were quite concerned about disrupting the professional lives of so many young practitioners who were either involved in postgraduate training programs or beginning practices.

I also asked the American Dental Association to continue their efforts to have dental officers included with medical officers in receiving the benefits of continuation pay and removal from limitations on promotions.

Retention of Dental Corps Officers

I am increasingly alarmed over the retention of Dental Corps officers. We have shown a steady deterioration in all categories since 1967. The following figures should be of interest to all:

	Fiscal Year			
	1968	1969	1970	1971 (Forecast)
Regular Army Strength				
Authorized	838	838	838	
Actual	722	715	687	(674)
Regular Army Applications	78	49	44	35
Senior Officer Retention				
. Resignations	8	14	18	20
Voluntary Retirements	7	10	18	30
Retention of Junior Officers				
(Other than Regular Army)				
% retention beyond 2 year tour	12%	10.1%	3.5%	

These figures reveal a steady deterioration in all categories since the enactment of P.L. 90-207 and P.L. 90-228. When one considers that the 3.5 percent retention of other than Regular Army officers includes those officers who extended to serve in certain overseas areas such as Europe, Panama, etc., which requires extension beyond two years to enable the officer to serve a normal tour in the command, the seriousness of the problem becomes evident. Where are the future Army dental officers coming from if we cannot induce the younger officers to make a career of the Army Dental Corps?

These figures have been brought to the attention of the proper authorities and it is hoped they will illustrate the seriousness of the problem and lead to corrective action.

Conference Travel for Dental Officers

In a recent Chief of Staff Summary Sheet, mention was made of conference travel for medical officers. It also contained information on funding. Dental officers were not mentioned. This was an oversight and General Jennings has indicated that there was no intention to delete other AMEDD officers from the provisions outlined in the Summary Sheet. Therefore, Dental Surgeons are advised that dental officers are to be considered for conference travel on the same basis as medical officers.

Celebration of Corps' Birthdays

It has become a traditon in the Army Medical Department for each of the six corps to observe its anniversary with an appropriate celebration. There has been no set format and no specific date for the celebration to be held. In some areas the celebrations were quite elaborate while in others formal recogniton of the birthdays was not made.

With The Surgeon General's strong emphasis on the "team approach" to the delivery of health care and his desire to bring all the corps together as an efficient, closely coordinated

team, the Policy Council in the Office of The Surgeon General recommended that individual corps' birthday parties be eliminated and replaced by an annual Army Medical Department birthday celebration. This party will include the six corps of the Medical Department and will be held on the same date in medical installations throughout the world. Each year one of the corps will be honored, which means that once every six years the Dental Corps will be the honored corps. The Policy Committee further recommended that every 25 years, each corps be authorized to have an individual birthday celebration which will be separate and distinct from the Army Medical Department birthday celebration.

The Surgeon General has approved these recommendations and a committee is now doing research to determine the most appropriate date for the celebration. It will be implemented during FY 1972.

WORSAMS

Considerable progress has been made in the implementation of WORSAMS (Worldwide Organizational Structure for Army Medical Support). The Chief of Staff was briefed on the study and he gave tentative approval to the concept. He directed that implementation regulations be developed with four areas in CONUS rather than the three originally recommended. He also asked that it be tested in an oversea area.

The Surgeon General emphasizes that, while the concept does not have full approval, there is promise that it may eventually be implemented. Implementation regulations are now being staffed and, if approved, WORSAMS will become a reality. Col. Willam D. Love, Deputy Chief of the Dental Corps, is the Dental Representative on the team drafting the proposed regulations.

Conference of Dental Surgeons

Each year in May, senior dental officers are brought to Washington to discuss the problems facing the corps and to learn of future plans and programs. It has been brought to my attention that some question exists regarding the method of selection of the participants for this conference.

As exists with all conferences, the number of funded spaces is limited. I wish it were possible to bring all of our senior officers together; however, the funding limitation precludes this possibility. Therefore, certain priorities have been established.

The two general officers, Army Dental Surgeons, and Dental Surgeons of oversea commands are automatically included. Most of the Dental Surgeons from larger CONUS installations are invited. The size of the installation, rather than the rank of the Dental Surgeon, is usually the deciding factor. Officers projected for important assignments in the next year are often included. Officers holding key positions, such as the Directors of the Research Units at Walter Reed and Letterman, and the dental officer at the Combat Development Command are invited. Officers who are to make presentations at the conference, who may not be included in the groups listed above, are included. Lastly, senior officers stationed in the Washington area are permitted to attend since they do not require funding.

In addition to covering the problems facing the corps and projected plans for the future, the 1971 conference dealt with the behavioral aspects of leadership and management. Jerome Barnum, who has been a leader in the Management Consultant Field for many years, directed this aspect of the program. As an innovation this year, a program was designed for the wives of the officers in attendance. We are hopeful that knowledge and attitudes developed through our association with Mr. Barnum will have far-reaching effects as we strive to improve the efficiency of our Corps.

Office Changes

Two changes in key positions in the Office of the Assistant for Dental Services, OTSG, will take place this summer. Col. George Kuttas, Assistant Chief of the Professional Branch, has been selected to attend the Army War College and he will be replaced by LTC Paul H. McFarland, Jr. Colonel McFarland has been serving as Chief of the Department of Dentistry and Chief of Oral Surgery at the 97th General Hospital in Frankfurt, Germany.

LTC Edwin L. Gasior, assigned to the Personnel and Training Division, has been re-assigned to Germany. He will be replaced by LTC Belman C. Maddox who has been serving as Deputy to the Dental Surgeon, USAREUR.

You can expect the same efficient and willing support from LTCs McFarland and Maddox that you have received from Colonel Kuttas and LTC Gasior. We hate to see these officers leave; however, we wish them continued success in their new assignments.

Liaison Officers in Dental Schools

In an attempt to improve communications between the Army Dental Corps and the students in the various dental schools, steps have been taken to appoint a member of the faculty of each school as the Army Representative in the school. This faculty member will be the contact for students having questions relating to the Army and, in turn, will be responsible for the dissemination of information relating to our corps.

First priority for appointment will go to Retired Army Dental officers serving on the dental faculty. Next priority will be faculty members serving as officers with reserve units. Retired and reserve officers of the other services will have the next priority and, if no faculty member is available who meets the above criteria, a member of the faculty who has expressed an interest in this program will be appointed.

The first appointment to be approved was Dr. Charles C. Alling, Chairman of the Department of Oral Surgery at the University of Alabama.

We hope to have appointments made in all dental schools by the time the schools convene this fall.

Around the Dental Corps

Fort Ord, Calif.

The Allyn D. Burke Memorial Symposium, formerly the Fort Ord Dental Symposium, will be presented 20-21 August 1971 at Fort Ord, Calif.

The theme will be "The Uncomplicated Three-Unit Bridge." Speakers for the two-day program will be COL Robert Sproull, William Beaumont General Hospital; COL Thomas Smith, Madigan General Hospital; LTC Robert Staffanou, Letterman General Hospital; LTC Edmond Cavazos, Fort Benning; LTC Reno Ahlvin, Fort Ord; and Dr. John E. Rhoads, Monterey, Calif.

Included in the program will be an afternoon of golf, evening social events, and a tour of the historical Monterey Bay Area for the ladies. Those interested in attending should write to: Allyn D. Burke Memorial Dental Symposium, c/o Dental Surgeon's Office, Fort Ord, Calif. 93941.

Madigan General Hospital Fort Lewis, Wash.

Study clubs have been organized in Periodontics, Endodontics, Preventive Dentistry, Practice Administration, Fixed and Removable Prosthodontics, Oral Pathology, and Oral Surgery. Clubs meet monthly and discuss journal articles and other developments in their area of interest.

Fort Belvoir, Va.

The Fort Belvoir Dental Activities hosted a dinner meeting with the Northern Virginia Dental Society on 12 April 1971. A program of 10 table clinics was presented by clinicians of the Fort Belvoir Dental Activities at Logan Dental Clinic followed by a social hour and dinner at Mackenzie Hall Officers' Club. Comments made by military guests and civilian colleagues indicated that it was a most enjoyable and instructive evening.

Mrs. Lucille Cavallaro, wife of MAJ Carl J. Cavallaro, DC, of the Fort Belvoir Dental Activities, was honored by being chosen Fort Belvoir's Military Wife of the Year. Mrs. Cavallaro was cited for her work in organizing more than 100 volunteer parents to work in Barden School located at Fort Belvoir. These parents are doing work in the school that enables the teachers to devote all their time to their students. Mrs. Cavallaro was later chosen First Army Wife of the Year and honored at a special luncheon at Fort George G. Meade, Md. LTG Seaman, former Commanding General, First US Army, presented an engraved silver tray to Mrs. Cavallaro.

Fort Dix, N.J.

During Children's Dental Health Week in February, COL and Mrs. James F. Parker, DC, presented their puppet show to local school children starting from pre-school age to sixth graders. They gave 57 performances to 6,442 delighted children.

Fort Eustis, Va.

In February the Fort Eustis Dental Detachment hosted area Armed Forces dentists and members of the Peninsula Dental Society at a dinner lecture dental meeting. MAJ John Harrison, Walter Reed General Hospital, spoke on conservative endodontic surgery.

Fort George G. Meade, Md.

The Western Shore Dental Society of Maryland sponsored its annual civilian-military dinner and Dental Seminar in January at the Fort George G. Meade Officers' Club. More than 175 persons registered for the meeting, which included civilian dentists, hygienists and assistants from the Western Shore Dental Society. Also attending were dental officers assigned to the U.S. Air Force Malcolm Grow Medical Center, and the U.S. Naval Academy, Annapolis, Md., as well as the Fort Meade dental staff. Following dinner, 13 table clinics were presented by representatives of the three services and the civilian society.

Fort Monmouth, N.J.

The Fort Monmouth dental staff joined with the local dental society and the American Cancer Society in observing Oral Cancer Detection Day on Wednesday, 21 April. Free screening was provided at Patterson Army Hospital, Jersey Shore Medical Center, Monmouth Medical Center and Riverview Hospital. Some 67 persons took advantage of the offer and two suspicious lesions were identified for treatment.

Fort Benning, Ga.

The Dental Activity has received approval for several significant projects related to the VOLAR program. The major item is $67,000 for improved dependent dental care capability. Five operatories for the Preventive Dentistry Clinic will receive new equipment and the orthodontic service will be expanded.

LTC Silas Crase appeared on a local television station in conjunction with National Dental Health Week. Dental health programs in the area were discussed in a symposium with local dentists. Another feature was the presentation of awards to winners of the Fort Benning School dental health poster contest.

A Red Cross Dental Assistants' Course was conducted during March by LTC Oswald Pennisi. 16 fine ladies attended and completed the course.

Brooke Army Medical Center

SGM Vera R. Halouska was promoted to that rank in March 1971. She is the first woman in the San Antonio area to receive such an honor. With her new rank, she has been named Chief, Military Occupational Test and Special Review Branch, MFSS. She is a former military dental assistant and is presently certified and a member of the Kansas Dental Assistants' Association.

A World War II temporary building has been refurbished and designated as the Oral Health Maintenance Center. It is being used primarily for the under-25 program. Two Siemens Orthopantomographs have been installed to provide panographic film capability in conjunction with initial examinations which will all be done here.

HQ, USARSO (Panama)

The Dental Service is now playing host to a Paraguayan Army Dental Officer, Dr. Roberto Almiran Barrios, for whom 16 weeks of on-the-job training in all phases of dentistry is being provided.

Dental plaque clinics have been started at both Fort Clayton and Fort Gulick. More than 1,000 patients have been seen in a two-month period. Ten-minute taped programs synchronized with 35mm slides point out the causes and prevention of plaque.

Europe

In conjunction with Dental Health Week, COL Dean Klevan participated in a 25-minute interview, "On the Scene" aired on AFN, Europe. CPT Gregory Hoeltzel also gave a presentation on AFN-TV in the same week. These are first two of many excellent presentations presented.

Dates for the 1971 Annual Dental Training Conference in Garmisch have been changed from 29 September-1 October to 22-24 September.

In conjunction with the 60th Anniversary of the Army Dental Corps COL Kenneth Hughes gave a 30-minute interview on AFN-TV on the "History and Development of the Army Dental Corps."

Pacific (Hawaii)

A Fort Shafter temporary dental clinic was opened 3 May with ceremonies conducted by MG Carl Hughes, Chief Surgeon, USARPAC. The clinic will be staffed with four dentists and two hygienists to provide more accessible out-patient dental treatment to troops in the Fort Shafter area. A new dispensary-dental clinic complex is planned to provide this service on a permanent basis.

Eight Red Cross volunteers at Tripler Hospital and nine at Schofield Barracks are being trained or have just completed training as dental assistants. They will be a great asset to increased dental capability at both clinics.

Pacific (Vietnam)

A concerted effort is being made to emphasize the need to the local populace for oral hygiene and its role in the control of dental disease.

CPT Ronnie D. Short with the help of the Chief Translator for CORDS, presented a lecture in Vietnamese to the Khanh Hoa Province Headmasters' meeting. About 170 Headmasters attended from all the schools in the area. The lecture was well-received and the Superintendent of Schools spent ten additional minutes lending his support to Captain Short's ideas. A copy of the lecture was given to each headmaster for future reference.

Pacific (Japan)

Four high school students have been assigned to the dental clinic at Camp Zama as part of the high school career planning program with school accreditation.

Pacific (Thailand)

Dental civic action is associated closely with the Lions Club of Bangkok. U.S. Army dentists join with approximately 24 Thai dentists and assistants to provide free care to blind children and orphans. This is accomplished on the first Sunday of each month in three Thai dental clinics: Doctor Som's clinic, Charemketra Clinic, and the Seventh Day Adventist Hospital Clinic.

Pacific (Korea)

As a part of the repositioning of U.S. forces, the 10th Dental Detachment has assumed responsibility for the dental clinics at Camp Howze and Camp Pelham. As the repositioning continues, the 10th Detachment will gradually assume control of all dental activities north of Seoul.

In February, Captain Moore of the Camp Howze Clinic visited Freedom Village in the Demilitarized Zone where 71 children and 18 adults were examined and treated. Freedom Village is a model Korean village set up in the DMZ and the only place in the zone where South Koreans may live.

Army dental officers in Korea continue to provide extensive off-duty support to orphanages as evidenced by the many trips reported. These are most worthwhile and provide tremendous impetus for the people to people program.

Pacific (Okinawa)

Rainfall during the last few months has been 15 per cent of normal, so water rationing is a distinct possibility. When water is turned off for rationing purposes, it becomes non-potable placing an extra burden on dental care since all water must come from engineer operated mobile tanks.

A mobile team has been organized to provide prophylaxes to bed patients in the hospital. The team consists of an LN hygienist and an assistant using a mobile cavitron and suction apparatus.

Awards and Decorations

The following awards and decorations have been reported to this office:

LEGION OF MERIT

COL Andrew CHRISTOPHER
LTC Ervin E. HUNSUCK

BRONZE STAR

CPT Henry A. MAXIM, Jr.
SFC James F. COLEGROVE
SP5 Garland E. TINER
SP5 Leonard A. SMITH (1OLC)

MERITORIOUS SERVICE MEDAL

COL John A. WATKINS, Jr.
MAJ Joseph CARSON
MSG William E. McDONALD
SFC Joseph O. McCOURT

AIR MEDAL

SFC Richard A. BURNS

ARMY COMMENDATION MEDAL

COL Henry C. THOMPSON (2OLC)
LTC Roger V. MAJERUS
LTC Francis A. SanFILIPPO (1OLC)
LTC David W. SHELTON
MAJ Alfred E. COLEMAN (1OLC)
MAJ John R. LaRUE
MAJ Edward SANTA
CPT Robert H. FOSTER
CPT Robert L. HALL, Jr.
CPT Richard L. JOHNSON
CPT Guy W. STONE, Jr.
1LT Donald T. CUTTIE
1LT John TRENHOLM
MSG Bobby W. DOWDY
MSG Bobby R. DOWELY
SFC Vernon L. AARON
SFC Mediavilia Jesus MORALES
SFC Billie PITTS
SFC Arthur SIMMONS, Jr.
SFC Donald L. ROGERS
SP5 Reynaldo O. CASTANEDA
SP5 Barry L. COLLIER
SP5 Ronald DURAN
SP5 Douglas M. GALLOGLY
SP5 Thomas G. HILL
SP5 Alan JORDAN
SP5 Wesley MAZE
SP5 Edward E. McGUIRE
SP5 Joseph A. MEYERS
SP5 Charles E. PATTERSON
SP5 Richard C. RADDOX

SP5 Michael SAPPARTO
SP5 Hubert L. REECE
SP5 Larry D. THOMAS
SP5 Merell R. YOUNG
SP4 Glen D. CONSTANTINE
SP4 William EAVES
SP4 Juan GONYALES
SP4 Thomas R. HOILES
SP4 Edwin I. MIRANDA-CHAPARRO
SP4 Roberto MUNIZ-FLORES
SP4 Richard STELLWAG
PFC Billy GRIFFIN

GOOD CONDUCT MEDAL

SSG Anthony F. RETEL
SP6 Jesse C. KENDRICK
SP5 Alan H. KOBLIHA
SP4 Wardell J. HUNT

TECHNICAL SERVICE MEDAL (1st Class)

LTC Joseph A. ZINGALE
MAJ Richard C. HOLDEN
MAJ Leonard A. MUENINGHOFF
MAJ Jack S. TRAWICK
CPT Charles CRAGUN

TECHNICAL SERVICE MEDAL (2nd Class)

MSG Louis A. FOXX
SSG John E. WILSON
SP5 Dana L. SANCHEZ
SP5 Dennis L. WADERICH

CIVIC ACTION MEDAL

LTC Joseph A. ZINGALE
MAJ Richard C. HOLDEN
MAJ Leonard A. MUENINGHOFF
MAJ Jack S. TRAWICK
CPT Vincent T. CAMMARATO
CPT Gary R. CHRISTMAN
CPT Leon R. DISCAVAGE
CPT Robert R. FARRINGTON
CPT Charles R. HARMON
CPT Gerald S. HOCH
CPT James G. JUDGE
CPT Robert W. LLOYD
CPT Joseph P. MAZZA
CPT Edward WOODMAN
1LT Roberto SANTANA
MSG Louis A. FOXX
SSG Melvin L. SELLERS
SP6 Dennis A. KURTZ
SP5 Brian G. ANKLEY
SP5 Reynaldo O. CASTANDA
SP5 Barry L. COLLIER
SP5 Barry E. CONSTANTINE
SP5 Joseph H. DELLORUSSO
SP5 David K. INMAN
SP5 Jerry W. MARTIN
SP5 Gary R. MILL
SP5 Dana L. SANCHEZ
SP4 Terry J. BROUSSARD
SP4 Glen D. CONSTANTINE
SP4 Thomas R. HOILES
SP4 Mark W. HUNTER
SP4 Bernard LANEY
SP4 Robert LOCKHART
SP4 Robert W. McAFEE, Jr.
SP4 Ronald B. THORNE

MERITORIOUS UNIT COMMENDATION

56th Medical Detachment (KJ) OLC

The 518th Medical Detachment (Den Svc) has been awarded the Meritorious Unit Commendation for distinguishing itself while in support of military operations in the Republic of Vietnam during the period 2 July 1967 to 31 May 1968. At that time the unit was commanded by LTC Isadore Peppe, who is to be congratulated for bringing the unit to such a high standard of performance.

The following officers have been board certified:

Oral Surgery

COL Thomas J. KING
LTC Kenneth D. BASS
LTC Alan E. DEEGAN
LTC Charles L. HUGHES
LTC Emery A. RUSSELL
LTC William R. SCHRIVER
MAJ John C. JONES
MAJ Joseph A. SALVO
CPT Stanley W. LANE

Endodontics

LTC Bernard D. WHITSETT
LTC Frederick L. COX

Periodontics

LTC Elbert WARREN

Recent Key Assignments

COL Robert Y. WHITTEMORE—Fort Jackson, S.C.

LTC Gerald R. OTT—Fort Carson, Colo.

LTC Leander T. GALLEGOS—Fort Benning, Ga.

LTC John J. VATRAL—Valley Forge General Hospital.

LTC Daniel M. POTTER—Fort Ord, Calif.

Death

COL Harry E. SMALLEY, Dental Corps (Retired) died on 10 March 1971 in San Antonio, Tx. He was 85.

List of Retirements for 3d Quarter, FY 71

April

COL Robert I. COCHRAN
LTC Shelley L. CAULDER

May

COL S. Kingdon AVERY
COL James W. OXFORD
LTC George A. OCHIKUBO

June

COL Donald O. LUNDQUIST

Postgrad Training Programs

The following additions and changes have been made in the FY 1972 postgraduate training programs:

General Dentistry

Additions:		
CUBA, Philip J., MAJ	Madigan GH	Madigan GH
HAMMOND, Harry I., LTC	Ft Knox	Ft Knox
HIRSCH, Edward L., MAJ	Ft Hood	Ft Hood
MOODY, Edward L., CPT	Ft Meade	Ft Hood
NEWBRY, Everett G., CPT	Ft Sheridan	Ft Ord

Oral Surgery

Changes in Training Asignment:	From	To
BLAHO, Daniel M., MAJ	Ft Bragg	Tripler GH
BROWN, Alan R., MAJ	USAIDR	Fitzsimons GH
EDMONDS, Peter D., MAJ	USAIDR	Wm Beaumont GH
McCLENDON, Earl H., MAJ	USAIDR	Tripler GH
THEISEN, Frank C., MAJ	USAIDR	Walter Reed GH

Pedodontics

Addition:		
MADDEN, John P., CPT	Ft Lee	Univ of Michigan

Removable Prosthodontics
Pre-residency Training

Addition:		
IVANHOE, John R., CPT	Ft Meade	RDA-WRAMC

Fixed Prosthodontics

Addition:		
GOODMAN, John T., CPT	Ft Wolters	Wm Beaumont GH
Deletion:		
TATUM, Richard C., MAJ	Ft Myer	
Change in Training Assignment:		
BOWLES, William F., LTC	Wm Beaumont GH	Walter Reed GH

Health Care Administration
MFSS

COCHRAN, Robert M., LTC	Ft Ord	MFSS
LARR, Edwin T., MAJ	MFSS	MFSS

Health Care Administration
Residents

DANIELS, Jon L., LTC	MFSS	Wm Beaumont GH
HOFFMAN, Jerry I., LTC	MFSS	Madigan GH

Command & General Staff College

GENOVA, James, LTC	Ft L. Wood	Ft Leavenworth
WILLIFORD, John, LTC	HQ, Third Army	Ft Leavenworth

War College

KUTTAS, George, COL	USAIDR	Carlisle Barracks

Veterinary Corps

BG Wilson M. Osteen, VC
Ass't for Veterinary Services

Fifty-Fifth Year of Service

On 3 June we celebrated the fifty-fifth anniversary of the Army Veterinary Corps. For all the members of the corps, I thank all the other members of the Army Medical Department for their continued support throughout these 55 years. I also express my appreciation to every member of the veterinary service, officer and enlisted, for their outstanding contributions to date, and hope for an even more successful future.

On 3 June 1916 congressional legislation authorized Veterinary Corps as part of the Medical Department. Before 1916 veterinary services were provided to the Cavalry, Field Artillery and the Quartermaster by organizational authorizations for Veterinary surgeons and farriers, but there was no veterinary service above the regimental, camp and depot levels. Therefore, the start of the Veterinary Corps provided for the first time an organizational structure to supervise veterinary activities professionally.

The Surgeon General, in early 1917, invited certain civilian veterinarians and officials of the American Veterinary Medical Association to confer with him on planning the new corps. A civilian advisory board was appointed and a Veterinary Division begun in the Surgeon General's Office in October 1917. The directorship of this Division was held by Medical Corps officers from 1917-1922 and by Veterinary Corps officers thereafter.

Interestingly, Section 16 of the National Defense Act, 3 June 1916, authorized veterinarians as follows: two officers for each regiment of Cavalry, one for each three batteries of Field Artillery, one for each mounted battalion of engineers, 17 as inspectors of horses and mules and seven as meat inspectors for the Quartermaster Corps. The authorization of 118 officers was filled in July 1918. Although the authorized strength was 126 at the start of World War II, a Veterinary Corps strength of some 2,200 officers was reached in 1945.

During World War II COL Raymond A. Kelser, VC, was named brigadier general, the first in the history of the Army Veterinary Corps to attain general officer rank. Currently the Regular Army authorization for the Veterinary Corps is 235, with an operating strength of just under 570 officers.

Also, I recognize the outstanding efforts Veterinary Corps officers have made to prepare for the broad scope of modern Army responsibilities. No longer can we support the Army by merely placing uniforms on civilian veterinarians. Modern technology for processing, transporting, and storing of food; investigative and supportive roles required by medical research and development, and the protection of the soldier from diseases transmissible from animals to man have dramatically changed our responsibilities during the past 55 years.

Currently 213 Veterinary Corps positons are identified and recognized as requiring officers with post-professional training in food technology, veterniary public health, laboratory animal sciences, microbiology, pathology, physics, biophysics, radiobiology and other specialty areas. To satisfy these requirements over 65 per cent of the 200 Regular Army Veterinary Corps officers now have post-professional specialized training to the masters and/or doctorate level. In additon, 14 officers are now enrolled in long-term civilian training with 13 officers selected to begin training during FY 1972. Eight will receive PhD degrees, the rest masters' degrees. Furthermore, 17 officers are in on-the-job preceptorship programs in veterinary pathology and laboratory animal medicine culminating in specialty board certification.

OPPOSITE PAGE: Chiefs of the Army Veterinary Corps since 1916.

55TH YEAR OF PROGRESS
U.S. ARMY VETERINARY CORPS

Gerald E. Griffin
1917

Ruben B. Miller
1917 – 1918

Charles F. Morse
1918 – 1922

John A. McKinnon
1922 – 1926

George W. Turner
1926 – 1930

WILSON M. OSTEEN
1968–

Chiefs U.S. Army Veterinary Corps
1916-1971

Walter Fraser
1930 – 1934

Robert J. Foster
1934 – 1938

Raymond A. Kelser
1938 – 1946

James A. Mc Callam
1946 – 1953

Jacob L. Hartman
1953 – 1954

Elmer W. Young
1954 – 1959

Russell McNellis
1959 – 1964

George A. Kuhn
1965 – 1968

Annual AVMA Army Meeting

The Army Veterinary Corps' meeting in conjunction with the annual joint American Veterinary Medical Association/Canadian Veterinary Medical Association will be held 20 July 1971, from 1300 to 1700 hours, in Room 3043 of Cobo Hall, Detroit, Mich. The Army Veterinary Corps is privileged to take an active role in the affairs of the AVMA. All Army Veterinary Corps officers, active, reserve, and retired are cordially invited to attend this meeting.

Graduate Training

A selection board met in February 1971 to consider all Veterinary Corps officer applications for graduate training beginning in FY 72. The following officers are to be congratulated upon being selected:

CPT Joseph C. DENNISTON, PhD—Physiology.
MAJ Michael G. Groves, PhD—Microbiology.
CPT Michael J. REARDON, PhD—Pathology.
MAJ Tommy S. Armstrong, M—OR/SA.
CPT William K. BURRIS, M—Food Technology.
MAJ Mylo M. HAGBERG, M—Food Technology.
CPT Harold W. Lupton, M—Microbiology.
CPT Glen E. MARRS, Jr., M—Pathology.
CPT Lawrence P. MAUL, M—Public Health.
MAJ George B. REDDIN, M—Public Health.
CPT Bennie RICE, Jr., M—Public Health.
CPT John H. SCHARDING, M—Public Health.
CPT William E. RIDDER, M—Public Health.

Officers interested in applying for long-term graduate level training at civilian institutions under the provisions of AR 350-219 are reminded that 1 December each year is the deadline for submission of applications for training beginning in the following fiscal year.

Private Practice

Paragraph 1-5e(1)-(4), AR 40-1, "Composition, Mission, and Functions of the Army Medical Department," 24 August 1970, permits private practice by Army veterinarians provided the listed prerequisites are met. Because of the frequent rotation of commanders and veterinarians, and because officials of local veterinary medical associations are normally changed annually, the following additional guidance insofar as Veterinary Corps officers participation is concerned is provided: The approval granted by a commander for a Veterinary Corps officer to engage in private practice should be reviewed annually for written compliance with all the prerequisites listed in paragraph 1-5e(1)-(4), AR 40-1, and the written permission of the commander should be renewed annually.

COL Wesley A. Clem, Jr.

It is with deep regret that I report the death of Retired Army COL Wesley A. Clem, Jr., VC. Colonel Clem died 28 February 1971 at the Theta Clark Hospital, Neenah, Wisc. He resided at 111 Wakawan Avenue, Fond du Lac, Wisc. He had retired from active duty in 1968.

Vet Support for Antarctica

In support of the Navy's Operation Deep Freeze austral summer operating season 1970-1971 was SFC Ludger C. Dufault, SSAN 038-18-3014, a veterinary food inspection specialist from Quonset Point, R.I. For the past four years veterinary food inspection specialists have been placed on TDY to Christchurch, New Zealand, to assist the U.S. Naval Support Force in Antarctica to improve the quality of fresh provisions consumed by the command. SFC Dufault arrived in New Zealand on 3 October 1970 and remained until mid-March 1971.

SFC Dufault's duties in New Zealand included the surveillance of all foods eaten by the Task Force in New Zealand and Antarctica and the sanitary inspection of New Zealand food processing plants supplying meat, dairy products, beverages, and produce. The major animal slaughtering and packing establishments in New Zealand have been inspected and approved to sell to the United States by the U.S. Department of Agriculture. SFC Dufault assisted the Navy Supply Officer in contracting with these approved meat processors for American style frankfurt and pork sausage and steaks. The bulk of the food items going to the Task Force was delivered by MSTS transport from Davisville, RI.

Other items of supply including over 10,000 pounds of fresh frozen porterhouse and T-bone steaks were transported from Christchurch to Antarctica by C130 aircraft.

CURIOUS ONLOOKERS: An Antarctic native and offspring pose for the camera. This is the fourth year an Army veterinary food inspection specialist has helped the U.S. Naval Support Force in Antarctica. (Photograph courtesy of U.S. Navy)

Short Course Successfully Completed

More than 50 military veterinarians attended the 1971 "Veterinary Medicine in Future Warfare" course at Walter Reed Army Institute of Research 16-19 February.

This course was designed to provide an effective means for the consideration, review, appraisal and communication of the newest developments in the Army Medical Department relevant to veterinary medicine. The course further provided an opportunity for a continuing education to the military veterinarian concerning the latest knowledge in selected subjects.

Both U.S. Army and U.S. Air Force veterinarians attended. The attendees' length of service varied from senior veterinarians with over 25 years' service to recent arrivals in the military service. Educational background and experience varied from the graduate veterinary level to those with advanced degrees and those with board certification in chosen specialties of veterinary medicine.

The program consisted of morning and afternoon lectures and papers presented by military veterinarians, civilians and other military guest speakers. The Division of Veterinary Medicine, WRAIR, under the direction of COL Earl W. Grogan, VC, hosted the program. LTC Richard G. Oakes, VC, was the Course Director.

The first day was opened with welcome remarks by BG Wilson M. Osteen, VC, Assistant for Veterinary Services, DA, OTSG: BG Charles H. Snider, VC, Assistant Surgeon General for Veterinary Services, USAF; COL Dale E. Wyckoff, MSC, Associate Director for Research Management, WRAIR, and Colonel Grogan. Colonel Oakes began the program by relating the continuing educational program to the course objective. He used the term "half-life" of lost knowledge and related it to the necessity of affording the opportunity to replenish a small portion of the lost knowledge through such courses as this one.

The first programmed speaker was COL Lewis H. Huggins, MSC, Executive Officer Directorate of Plans, Supply and Operations, OTSG. He provided the attendees with an up-to-date briefing and discussion of World-Wide Organizational Structure for Army Medical Support (WORSAMS). The main theme of the rest of the program encompassed the use of the military dog, and papers covering medical problems and techniques in selected subject areas.

The remaining speakers and their subjects in program order were:

LTC James H. McNamara, USAF, VC, HQS, USAF: "Nutriton, Kenneling and Housing of Military Dogs."

COL Merida W. Castleberry, VC, Edgewood Arsenal: "Bio-Sensor Research Program."

Dr. Oscar W. Schalm, University of California, School of Veterinary Medicine: "Clinical Canine Hematology."

COL Floris M. Garner, VC, AFIP: "Interesting Observations of 2000 Necropsies of Military Dogs."

Dr. Alan M. Klide, University of Pennsylvania, School of Veterinary Medicne: "Anesthesiology."

MAJ Dock F. Dixon, Jr., USAF, VC, Lackland AFB: "Hip Dysplasia and Dental Techniques as Applied to the Military Working Dog."

COL George F. Dixon, VC, 1st U.S. Army: "Lessons Learned in Vietnam."

LTC Paul K. Hildebrandt, VC, WRAIR: "Necropsy."

Dr. Leonard H. Binn, WRAIR: "Review of Canine Viruses."

Dr. John T. McGrath, University of Pennsylvania, School of Veterinary Medicine: "Neurological Examination of the Dog."

LTC Thomas J. Bucci, VC, Graduate Student, Universty of Colorado, Denver: "Prevention and Management of Heat Exhaustion."

Dr. Robert M. Schwartzman, University of Pennsylvania, School of Veterinary Medicine: "Dermatology."

Dr. William G. Magrane, Private Practitoner, Osceola, Ind.: "Pannus in the German Shepherd, Medical and Surgical Control."

Several panels were conducted and consisted of representative speakers both military and civilian. The first panel discussed Civic Action and Veterinary Assistance in Foreign Countries. Its members were:

COL George F. Dixon, VC, Fort Meade, Md.
LTC Robert P. Ryan, VC, Fort Jackson, S.C.
LTC Paul K. Hildebrandt, VC, WRAIR, Washington, D.C.
MAJ William H. H. Clark, VC, MFSS, Fort Sam Houston, Tex.
LTC Thomas J. Bucci, VC, University of Colorado, Denver, Colo.

Tropical Canine Pancytopenia and Canine Babesiosis were the subjects of a discussion for another panel. The lead-off speaker was MAJ David L. Huxsoll, VC, WRAIR, followed by LTC Paul K. Hildebrandt, VC, and MAJ Michael G. Groves, VC, also of WRAIR.

The final discussion group held on the last day of the course was directed toward Selected Canine Zoonoses. Major Huxsoll, Major Groves and Dr. Aaron D. Alexander, WRAIR, made up this panel. The program was closed with the showing of a new film "Organic Phosphate Toxicity in the Canine." This film was produced and filmed under the technical supervision of the Division of Veterinary Medicine, WRAIR.

Next year's course, currently scheduled for 14-17 February 1972, will be titled "Symposium on Military Veterinary Medicine."

Veterinary Corps in Iran

The U.S. Army has provided Veterinary Advisors to assist Iran for the last ten years. The most recently returned officer is MAJ William H. H. Clark, VC, Assistant Chief, Veterinary Science Division, U.S. Army Medical Field Service School. He served during 1968-70 as mission veterinarian and as veterinary preventative medicine advisor to the medical departments of the Iranian Army, Navy and Air Force. The following material was extracted from Major Clark's end-of-tour comments and provides a brief insight into the veterinary medical problems in the ancient land of Persia.

The Imperial Iranian Army has the largest Veterinary Corps of the military services with approximately 85 per cent of the total number of Iranian military veterinarians. The Corps' mission has changed in the last decade from a service providing animal care to a service providing veterinary preventive medicine and food inspection. This change has developed a requirement for new regulations, food specifications, sanitary standards, inspection procedures, training and research. U.S. publications have provided some

guidance, but are of limited value since Iranian eating habits, food resources, and manufacturing capabilities differ greatly from those in the United States.

Parasitism Prevelent

Major Clark reported that parasitism is one of the greatest limiting factors to livestock production in the Middle East. Hydatid cysts, *Fasciola hepatica, Fasciola gigantica* and *Dicrocoelium dendriticum, Dicthocaulus* spp. are commonly seen as the *Cysticercus bovis* and *sarcosporidiosis*. Effective antemortem and postmortem inspection service is provided by the governmental veterinary service. Cases of camel pox, goat pox, foot and mouth disease and glanders are uncommon but can be found. One of the most dramatic events Major Clark observed during his tour was an epizootic of rinderpest in 1969. Imported cattle were thought to be responsible and thousands of cattle died within the first two months after first animals were imported.

On Labor Day 1968, one of the most devastating earthquakes in Iranian history struck Northeastern Iran. Two separate quakes, about 12 hours apart, killed some 12,000 people. Major Clark was a member of the MAAG/U.S. Embassy team which flew to the earthquake area to attempt to determine what U.S. medical assistance might be needed. The agency in charge of rescue and relief operations was the Red Lion and Sun Society (Iranian Red Cross). The area was first surveyed by air, and medical priorities were determined. Medical resources were allocated by priority as they became available.

Patients were given first aid, transported to a central facility and later evacuated outside of the earthquake area for convalescent care. Many patients survived being buried two days and a few up to three days. One woman, found the second day, had given birth while buried and both boy and mother recovered. It was soon evident that help from the U.S. field medical resources in Europe was not needed and the team returned to Teheran recommending only that the Red Lion and Sun Society be congratulated on its demonstrated ability to cope with a very difficult situation.

Goat Garbage Disposals

From a veterinary public health aspect, Major Clark's tour was interesting. Human titers to *Brucella,* were common, possibly derived from the consumption of a local soft cheese made from goats milk. During 1968-1969 one case of brucellosis and several suspected cases of Q fever were recognized within the American military community, presumably derived from milk products. It was observed that one or two herds of 15-20 sheep and goats were a part of the garbage disposal system of each housing area. The high incidence of Brucellosis and probably Q fever in these herds and their close proximity to all inhabitants provided numerous possibilities for transfer of these diseases, especially during the lambing season.

Infectious hepatitis was always a potential problem. One episode placed some 40 U.S. personnel in the hospital through the use of contaminated ice. Only the larger cities had chlorinated water supplies. Teheran had a potable central water supply which reached most of the housing areas. Each house, however, had its own sewage system consisting of a hand-dug well approximately 60 feet deep, and a system of tunnels radiating from this central well. The loose soil permitted this to be a highly efficient waste disposal system. These wells were not trapped so problems sometimes existed with sewer gas just after a rain. As the waste water flowed through these wells and tunnels, it tended to wash some of the dirt from the sides and wells enlarged. Streets and yards have been known to disappear suddenly into these growing underground caverns.

The number of cases of rabies was amazingly small considering the potential. Shepherds brought their dogs to the city when their flocks were sold and the dogs were left behind. These dogs collected in packs of 10-15, slept by day, roamed the streets by night, ate whatever they could find, fought, and bred. Estimates vary but at one time an estimated 15,000 dogs roamed the streets of Teheran alone. Yet, Major Clark reported they saw only about one case of rabies every six months and it was usually the dumb form. The best remembered case involved a half-cared-for street dog. During the rainy season, she had pups in a ditch and a few days later became ill. The local children and parents fed the pups and attempted to hand feed the dog, but she soon became comatose and died without showing signs which would point to any particular disease. The father had seen a film, shown to the Boy Scouts, on rabies and requested a brain examination. The animal was positive and five people were given postexposure antirabies prophylaxis.

Echinococcus

In Major Clark's opinion, Echinococcus (echinoccosis) in dogs presented a far more important public health problem than rabies. One investigator estimated that 5-15 per cent of the street dogs were carriers. Intestinal parasitism was not uncommon among the American personnel who had been in-country for awhile. One individual passed seven feet of Taenia, but amebiasis, giardiasis, and ascaridiasis were the usual conditions seen.

In addition to Major Clark's professional veterinary duties, he assisted as a member of the MAAG in providing professional assistance to the Iranian medical departments in determining training requirements, reorganization of the major medical headquarters, development of a field medical capability, development of medical TOEs, and advising in hospital staffing and in medical supply management.

Major Clark's assignment in Iran proved to be an enjoyable experience for himself and valuable from a professional veterinary military standpoint.

Veterinary School Graduates 28

On 5 March 1971, 28 enlisted students graduated from the 321-91T20, Course No. 5, conducted at the Veterinary Specialist School, Walter Reed Army Medical Center. Five such courses are given each year by the Division of Veterinary Medicine, Walter Reed Army Institute of Research. The curriculum provides studies in the basic principles of animal medicine.

Within each class, the three top men receive letters of commendation for scholastic achievement. The top three men in this class were (from left to right in photograph) E2 Donald R. Weisgarber, Navarre, Ohio; E2 Ronald R. Bielen, Mosinee, Wisc.; and E2 Loren G. Book, Navada, Iowa. Each was promoted to E3 upon graduation.

In each class, one man is singled out to receive a plaque awarded by the Association of the United States Army. The recipient of this award must have attained certain academic achievements and established a record during his tenure to be worthy of recognition for his endeavors by the United States Army. Specialist Bielen received this award. He also served as the class leader.

SCHOLARS: Letters of commendation for scholastic achievement at Course No. 5 at the Veterinary Specialist School, Walter Reed Army Medical Center, went to *(left to right)* Donald R. Weisgarber, Ronald R. Bielen and Loren G. Book. They were promoted to E3 upon graduation.

Changes and Awards

Unit Inactivations

459th Veterinary Detachment (Small Animal Dispensary) 15 Mar 71
522nd Medical Detachment (Veterinary Hqs) 15 Mar 71
936th Medical Detachment (Veterinary Hospital) 15 Mar 71
176th Medical Detachment (Veterinary Service Large) 15 Apr 71

Key Assignments

COL M. A. BEERWINKLE—6A USATC Inf Fort Lewis
COL J. E. HENDERSON—Vet Det Presidio of San Francisco
COL K. W. LORENTZEN—MEDDAC Ft MacArthur
COL H. M. MILLER—OTSG Washington, D.C.
COL W. J. SHAY—Vet Det Japan

Retirements

COL Herbert R. FAUST
COL George M. HUGHES
COL Wilbert M. KLETT
COL Millard L. TIERCE, Jr.
LTC John Q. ADAMS
LTC Gerald F. SCHROEDER
MSG Andrew M. GIBSON, Jr.

Awards and Decorations

The following awards and decorations have been reported to this office:

Legion of Merit

COL Stephen G. ASBILL—2nd OLC
COL Heyward G. BROWN—1st OLC
COL William S. GOCHENOUR, Jr., 1st OLC
COL James M. LYDAY

Bronze Star Medal

MAJ Paul B. JENNINGS, Jr.
CPT Gary F. BECK
CPT Frederick L. HELM
CPT Leslie R. PERRY

Air Medal

CPT Frederick L. HELM

Meritorious Service Medal

COL William G. BROOKS
COL Robert B. GREINER
MAJ Thomas J. BUCCI
MAJ John T. ERVIN
MAJ David K. HYSELL

Army Commendation Medal

LTC George F. FISCHER—2nd OLC
LTC Gerald D. GAINES
MAJ Tommy S. ARMSTRONG
MAJ James C. COOPER
MAJ Edward H. STEPHENSON
MAJ Robert J. WOOTTON, Jr.
CPT Jerry D. BELL
CPT Eddie L. CARLISLE
CPT William C. HALL
CPT Charles W. HENRY
SFC Hideo ARAKAWA
SFC Dane R. HENRY
SFC William M. ROBERSON
SSG Edward E. HONDA

Medical Service Corps

BG Manley G. Morrison, MSC
Chief, Medical Service Corps

My Fellow Officers

During this past May, I had the distinct privilege and pleasure of accompanying Major General Neel, our Deputy Surgeon General, on visits to Army Medical Department units and activities located in Turkey, Italy and Germany. From my point of view, these joint visits proved highly productive. As a result of our visits and subsequent discussions, I gained many insights into our AMEDD support effort in the aforementioned countries which I had not previously had.

I thank all officers who were responsible for making our visits so professionally rewarding. Invariably, we were provided outstanding briefings; briefings which focused not only on mission, organization and accomplishments, but also on problems and frustrations. This is as it must be if we are to advance as a medical support system. I applaud their candor, and ask that they maintain their spirit of open and frank discussion.

Meet the New Assistant Chiefs

In the April 1971 issue of our AMEDD *Newsletter,* COL Herb J. Thompson, MSC, who served as one of our Assistant Chiefs and concurrently headed the Optometry Section of our Corps, announced his retirement from active duty. Since that time, it has been decided that COL Ralph W. Morgan, MSC, who also served as an Assistant Chief and concurrently headed the Medical Allied Science Section of our Corps, would join COL Ed Krise, MSC, at the newly established, and highly important, Race Relations Institute.

I am delighted to announce that Lieutenant General Jennings, The Surgeon General, has appointed COL Donald H. Hunter, MSC, to head our Medical Allied Sciences Section and COL Henry E. Maes, MSC, to head our Optometry Section. Both of these fine officers will also serve as Assistant Chiefs of the Medical Service Corps.

I ask you to carefully examine the following biographical sketches. I am confident that these two officers will provide competent leadership and professional direction for the sections of the Corps they now head.

COL Donald H. Hunter, MSC

Colonel Hunter was born in Madison, S.D., in 1917. Mrs. Hunter was born in Rutland, S.D. The Hunters have a daughter, Susan, working at the University of Pennsylvania in Philadelphia, and a son, David, who will graduate from the School of Architecture at Clemson University this summer.

Colonel Hunter earned his bachelor of science degree in chemistry from South Dakota State College in 1939 and the master of science degree in bacteriology from the University of Wisconsin in 1941.

In September of 1941, he joined the Hansen Inoculator Company of Urbana Ill., for the purpose of developing a liquid culture technique as a replacement for the traditional solid culture methods which were then dependent upon Japanese-produced agar-agar. From here, he was drafted into the Army at Camp Grant, Ill., in January 1942.

From January 1942 to August 1943, Colonel Hunter served as an enlisted man in the Army Air Corps at Scott Field, Ill., acting as bacteriologist and finally as NCOIC of the hospital laboratory. He was commissioned a second lieutenant in the Sanitary Corps in August of 1943 and served briefly with the 9th Medical Field Laboratory at the Desert Training Center in California and then joined the 7th Medical Field Laboratory which supported Patton's Third Army during the European campaign. He served in this unit

as Chief of the Serology and Bacteriology Departments and as its Mess Officer, Motor Officer and Detachment Commander until he was relieved from active duty in January 1946.

He rejoined the Hansen Inoculator Company as bacteriologist in charge of research and production until he was recalled to active duty in November of 1949 as a clinical laboratory officer and Chief of the Laboratory Service at the United States Army Hospital at Camp McCoy, Wisc.

During their stay at Camp McCoy, Colonel Hunter and his family made the important decision that a career in the U.S. Army was to be the life for them. He became a voluntary indefinite reservist and later was integrated into the regular Army in April of 1958.

From Camp McCoy he went to the Fourth Army Area Laboratory at Fort Sam Houston, Tex., in March of 1952 as Chief of the Bacteriology and Serology Departments; to the Walter Reed Army Institute of Research in September of 1954; to the USAREUR Medical Laboratory in September of 1956; back to the Walter Reed Army Institute of Research in August of 1960, where he became Chief of the Bacteriology Department in April of 1962; then to the Republic of Vietnam in September of 1966 as Chief of the Plague and Enteric Laboratories.

During his busy career as a soldier scientist, Colonel Hunter has found time to author and co-author a great many scientific articles and reports in the fields of medical bacteriology and immunology. He is the holder of the coveted "A" Prefix to his primary MOS. Interspersed with these scientific responsibilities, he developed his military management expertise by performing such duties as Assistant Registrar, Pharmacy Officer, Detachment Commander, Motor Officer, Mess Officer, Supply Officer and Administrative Assistant. He is currently making every effort to provide more formalized training of this type for the developing soldier scientists.

Colonel Hunter proudly wears the Legion of Merit and the Meritorious Service Medal.

COL Henry E. Maes, MSC

Colonel Maes was born in December 1919, in Moline, Ill., and is married to a former Army Nurse Corps officer, Elizabeth A. (Pesut) Maes, a native of Indianapolis, Ind.

Colonel Maes entered the Army as an enlisted man in the Army Ordnance Department in January 1940. While he was stationed at Fort Buchanan, Puerto Rico, World War II was declared and Colonel Maes entered the Officer Candidate School program at Fort Lee, Va., graduating in 1942. After serving in the European Theater of Operations from 1943 through 1945, Colonel Maes accepted a reserve commission and reverted to a civlian status. He enrolled in the Illinois College of Optomerty and graduated in 1949 with the degree of Doctor of Optometry. In February 1952, he re-entered the Active Army and has served continuously since that time.

Colonel Maes' initial MSC assignment after attending the officer basic course in 1952 was as an optometrist at Fort Lewis, Washington. His next assignment was Chief of Optometry Section, Tokyo Army Hospital. He completed the MSC Officer Advanced Course in 1959 and was assigned as Medical Operations Officer, Headquarters, 5th Region ARADCOM from 1959 thru 1961. During 1962, he served in Vietnam as an Advisor to the RVNAF Logistics Management School and J-4. Subsequent assignments were to CDC, Medical Service Agency 1963-67, and Army Research Office, OCRD, DA, 1968-1969. He is presently assigned as Chief, Manpower Management Group, Resources Management Office, Office of The Surgeon General.

Although Colonel Maes has been employed outside of the optometry clinic in recent years, he has continuously updated his knowledge and maintained his professional proficiency as an optometrist.

Colonel Maes is a 1964 graduate of the Associate Command and General Staff College and has been awarded the Meritorious Service Medal and the Army Commendation Medal with Oak Leaf Cluster.

VOLAR Update

Recently I presented a speech at the Current Trends in Health Care Administration Professional Short Course which contained many of my ideas about the Modern Volunteer Army. I want to share a few of them with you. Following are extracts from the aforementioned speech:

> What are the Modern Volunteer Army's direct implications for medical organization and administration? I do not intend to propose a blueprint for action; instead, I propose only to put forward some of the things that I think must be considered, and perhaps changed, if we as members of the AMEDD health care team are going to do our part to maximize the Modern Volunteer Army's chances for success.
>
> I am going to be candid. Some of the things I have to say may prove to be wrong in the final analysis. You may disagree with my viewpoints, but at this time I must present them, because I believe they are right.
>
> The Modern Volunteer Army is doomed to failure if it loses touch with the society it is designed to serve. We must continue to recruit from a broad base. We must insure that our recruitment and retention efforts are aimed at qualified individuals of all races and creeds. We must guard against the distinct possiblity that our Army could again become a regional Army. Dr. Morris Janowitz, a world-renowned sociologist who has perhaps done more work with the American military than any other civilian social scientist, pointed this out as one of his major concerns about the Modern Volunteer Army. He reminded us that prior to World War II, our Army was essentially *rural* and essentially *Southern*. We in the AMEDD must administer our health care recruitment and retention programs so that regionalism does not engulf us. Likewise, we must seek racial balance. Obviously, we do not want an all white Army, nor do we want an all-black Army. We want an Army representative of our society.
>
> Education will be of paramount importance within the Modern Volunteer Army. We in the AMEDD should be thinking now of new and innovative programs which will maximize the effects of our training dollar. Service schools, such as the Medical Field Service School, which have done such an outstanding job for us throughout the

years will grow in importance. We must insure that they receive our full and continuing support. This is the age of rapidly expanding knowledge, and I am convinced that a quality program of continuing education will do much to attract and retain quality people.

I want now to move into a sensitve area—an area that requires our continuing attention. You may or may not know that General Jennings, our Surgeon General, has been making a concerted effort to identify positions within the Army Medical Department currently held by physicans which could be converted to non-physician positions with no loss of effectiveness. Much progress has been made, but I am convinced that we must go further. All of my contacts with young physicians lead me to the same conclusion. Our doctors want to practice *clinical medicine,* and duties which take them away from such a practice are viewed with great disdain. If we are going to retain high quality young physicians, we must do even more to rid them of duties than can legitimately be handled by non-physicians. I feel the foregoing presents a significant health care organizational challenge. No one will deny that the recruitment and retention of physicians will be one of the Volunteer Army's toughest problems. I strongly believe that a major step toward solution of this problem will be full recognition of the fact that today's young physicians want to practice clinical medicine. Our organizational challenge is to see that they are given maximum opportunity to do so.

My next point concerns a frequently voiced complaint in our hospitals. A Volunteer Army—smaller, more highly paid—will be expected to operate more effectively. Wasting scarce manpower in long waiting lines for processing and for receipt of services will have to be absolutely minimized, not only to conserve manpower, but also to eliminate the legitimate irritation that such lines create. This presents an ongoing challenge for the medical administrator. Surely it is not a new problem, but I can assure you it will now receive even greater attention.

At this point, I want to ask what I consider a key question. I ask you to think about this before answering. For whose convenience is our present health care system organized—the patients we serve, or our own? As I see it, this question gets at a "gut" issue. If we are going to rationally organize and administer a health care system that will attract and retain, instead of repel, young Americans, it must be a system designed not for our own convenience, but rather for the convenience of the persons it is designed to serve.

In fairness, I must point out that much serious thought is being given this question. The Army hospitals at Fort Benning and Fort Hood run full-service outpatient clinics at night and on weekends —for the *convenience* of the people they serve. I'm sure there are many other examples of progress in this area, but I feel very strongly that this is a question we must continue to ask ourselves—for whose convenience are we organized? Does our organization really take the young mother with the sick child into account? Are we really organized to make it convenient for her to seek our services, or do we ask her to present her ailing child at a time when her husband is at work—when she may or may not have transportation—when it is difficult for her to get baby sitters for her other children because all the neighborhood teen-agers are in school? I would remind you that to the young wife, these are key considerations. They spell the difference between a positive and a negative attitude about our medical service and about life in the Army, and they frequently spell the difference between her husband's staying in the Army or getting out as soon as possible.

Now to move to my last major area of concern. I trust that each of you has read the letter on AMEDD personnel attitudes that General Jennings recently wrote to each hospital commander, to all major command surgeons, and to the commanding officers of our class II installations. I share General Jennings' grave concern in this important area. If the Modern Volunteer Army is to become a reality, we must prove to each man that he *really counts* as an individual. We in the Army Medical Department must do our part. The volume of critical mail now reaching General Westmoreland and General Forsythe is convincing evidence that we have considerable room for improvement in this area.

What seems to be the problem? We are accused of harboring people within our organizations who convey by their speech and their actions indifference or disinterest. We are accused of treating our enlisted soldiers like second-class citizens. We are accused of depersonalizing the most personal of all services available to the soldier and his dependents. One soldier recently wrote that despite a college education he was made to feel like the 'village idiot' everytime he entered one of our hospitals.

Judging from the widespread complaints of a similar nature, it appears as if we do, in fact, have a problem of major proportions. Significantly, the overwhelming number of complaints focus not on treatment, but on attitude.

We must come to grips with this problem or the chances for success of the Volunteer Army could be seriously jeopardized. We must develop our staffs to the point where there is full recognition by all that treatment starts not at the door leading into the doctor's office, but rather at the door leading into the hospital.

Somehow we must get the members of our staff to recognize the fact that the quality of their interaction with each patient is having a major affect on that patient's attitude concerning his total medical care. We cannot tolerate anything less than gentle, understanding, concerned care.

We must get rid of the syndrome which causes many of our people to automatically suspect that the majority of our enlisted soldiers who show up for sick call are gold-brickers. This syndrome is self-defeating and must be eliminated.

We must remember that we are a service organization. Service organizations have no place for employes with haughty or indifferent attitudes.

I think General Jennings provided us with an excellent guide for action when he charged us in his recent letter to ". . . treat each patient as we would expect a member of our immediate family to be treated." He further stated that, "Courteous treatment should extend from the highest level of hospital management to the lowest and should begin with the clerks manning the desks in all clinics from whom vital first impressions are received." He pointed out that, "It is the responsibility of each commander to develop and actively encourage these attitudes, but the burden must be shared by *everyone* both in the patient care and administrative areas."

Gentlemen, these then are our challenges—difficult, yes, but not impossible. If the Modern Volunteer Army is to succeed, and if it is to result in a better Army, we must do our part.

I charge each of you to examine your own hospitals and clinics objectively and critically. Does your facility now satisfy the frequently written three "A's" of health care? Have you really maximized, within the limits of your personnel resources, the *availability, accessibility* and *acceptability* of health services for your patient population?

Have you done your part to personalize and humanize the services rendered? If you agree with my thesis that "rudeness breeds rudeness, and discourtesy breeds discourtesy," then I ask you not to accept either form of behavior from any member of your staff. The usual excuse for rudeness is, "I'm busy. I'm in a hurry, I have no time for frills." To this I say, *nonsense.* People who are really busy always seem to have all the time in the world for other people.

I know there is much that we can do. I know that we are now working and making progress in most of the areas I have discussed. I am well aware of the fact that many of our hospitals have initiated programs similar to Fort Belvoir's "Concerned Care" or Fort Benning's "We Care" programs. I ask, however, that you go even further. I ask that you re-examine your basic aims and objectives and while doing so, keep the advice of Peter Drucker in mind when he states, "The most difficult and most important decisions in respect to objectives are not what to do. They are: First, what to abandon as no longer worthwhile and, second, what to give priority to and what to concentrate on." I ask that you give top priority to, and concentrate your efforts upon, those things that will enhance the Modern Volunteer Army's chances for success. I feel very confident that you will find no significant disagreement between your basic philosophy of health care and the key tenets of the Modern Volunteer Army. Both emphasize personalization. Both focus central importance on man's right to a life of dignity and respect."

MSC Anniversary Celebration

Just before departing Washington for Europe on 3 May, we celebrated the 54th Anniversary of the founding of the Medical Service Corps at a huge and extremely successful reception at Walter Reed's Officers Club. Throughout Europe I also had the privlege of cutting a few anniversary

54TH ANNIVERSARY: BG Manley G. Morrison, Chief, Medical Service Corps, and his daughter, Sandy, prepare to cut the MSC 54th anniversary cake. With General Morrison and his daughter are *(left to right):* COL and Mrs. Bernard L. Goldstein; COL and Mrs. Ralph W. Morgan; COL and Mrs. Andrew J. Colyer; and COL Herbert J. Thompson. Mrs. Morrison was ill and could not attend the celebration.

cakes and passing on my thoughts on the occasion of our anniversary. In all instances I announced that this celebration would be our last; that henceforth there would be an annual Medical Department Anniversary Celebration. The precise date of this anually recurring celebration is still to be announced.

The decision to forego individual Corps' anniversary celebrations was made by The Surgeon General's Policy Council. I want you to know that I supported this decision at the time it was made. Why? Because I feel very strongly that AMEDD unity is of paramount importance. We must do all we can to forward the "team concept" for the Army Medical Department. Following are a few of the remarks I made at our 54th Anniversary Celebration at Walter Reed:

> You must learn to respect each member of our team for the contributions that he or she makes to the total team effort. It's not that you have to like everyone, but you certainly must respect each team member for their contribution in support of mission accomplishment. There is no one individual, no single element, regardless of profession or area of specialization, that is independent of our organization. All are interdependent—and we must never forget that.
>
> General Jennings has said many times that we have something to offer the entire system of medicine throughout the United States. What do we have? We have an organization based on the team concept for the delivery of comprehensive health services. So it is exceedingly important that we hold this team together and continue to move forward.

I should also tell you that each year at the proposed AMEDD Celebration, one of our six corps will be highlighted and honored. This will be done on a rotational basis, so every sixth year the "silver cadeceus" will have center stage at the anniversary celebration.

Position on Special Pay for Optometrists

I think it imperative that all MSC officers know and understand my position on the provision in the Military Compensation Bill now being considered by the Congress which would authorize a special or incentive pay for optometrists serving as commissioned military officers. On 5 April 1971 I sent a letter to LTG Jennings, The Surgeon General, stating my opposition. Subsequently, General Jennings put a supporting indorsement on my letter and forwarded it to the Deputy Chief of Staff for Personnel. Following is an extract from my letter:

> Since being appointed Chief of the Army Medical Service Corps on 1 August 1969, I have been steadfast in voicing my opposition to such a proposal. While I cannot deny the validity of the American Optometric Association's claim that the Armed Services will continue to experience great difficulty in the recruitment and retention of optometrists unless their level of compensation is improved. I must, in good conscience, point out the following.
>
> ● There are other specialty areas within the Army at large, wherein required educational levels, civilian demand, and mean civilian earning levels are as high or higher than they are for the specialty of optometry. Therefore, to award a special pay to optometrists only, in my opinion, is inequitable and contraindicated.
>
> ● The awarding of a special pay to optometrists only has the very real potential for causing a serious split between officers in this small, but very important career field and officers in the 19 other equally important career fields comprising the Army Medical Service Corps.
>
> ● The awarding of a special pay to optometrists in the Army Medical Service Corps has the dangerous potential for isolating the Medical Department from the Army it is designed to serve. Presumably, this is true in the other Services as well.
>
> It has been my constant hope that the problem of adequate compensation for offices with special, much-in-demand skills will be solved not with piece-meal legislation, but rather with comprehensive legislation arrived at as a result of a thorough, objective survey of the Armed Services' real requirements in relationship to levels of training, civilian demand and civilian levels of earning. Only if this is done can we hope to avoid the bitterness and acrimony that will almost certainly occur if small specialty groups are singled out for pay increases while other equally deserving groups are not considered. My staff is presently gathering data to support such a survey for the specialty areas represented within the Army Medical Service Corps.
>
> Unquestionably, the area of additional compensation for hard-to-attract-and-retain specialists will require top-priority attention in the immediate future. Optometry will in all likelihood be one of the specialty areas requiring adjustment. The enactment of a special pay for optometrists only at this time, however, is likely to create more problems than it solves. If you agree with the foregoing comments, I recommend they be forwarded to the Chief of Staff for his consideration.

Assignment of LTC Al Schiavone

Upon the departure of LTC Van Straten to attend the Command and General Staff College, LTC Albert L. Schiavone, MSC will be assigned as my assistant. Colonel Schiavone will be returning from Vietnam where he has been assigned as the Executive Officer of the 68th Medical Group at Long Binh.

Officers wishing to submit items for inclusion in the MSC Section of the AMEDD *Newsletter* should henceforth send them to:

LTC Albert L. Schiavone, MSC
Office of the Chief, MSC
OTSG, DA
Washington, D.C. 20314

Junior Officer Forum

In the April 1971 issue of the AMEDD *Newsletter,* I solicited junior officers' comments regarding the desirability of establishing a Junior Officer Forum in the MSC Section of the *Newsletter.* Since this is being written in May to meet the printer's deadline, there has not been sufficient time for junior officers to get their comments regarding this proposal to me. I shall report the results of our survey in the October 1971 issue, and if there is sufficient interest, I shall announce the format preferred by junior officer respondents.

In Memoriam

"He was a commander, a close friend, a big man, a tough leader."

These words were used by COL Richard Stacey, MSC, during a recent memorial plaque unveiling ceremony at Einseidlerhof, Germany, to describe COL Frank D. Godwin, MSC, the former Commander of the U.S. Army Medical Materiel Center, Europe, who died this past March.

Colonel Godwin had departed the Medical Materiel Center only three months previously when he died. He was assigned to Martin Army Hospital, Fort Benning, at the time of his death.

Survivor Assistance Officer

Recently it has come to my attention that some of our MSC officers have been objecting to their being given the additional duty of Survivor Assistance Officer. I regard this duty as being extremely important and requiring mature judgment, sensitivity and human compassion.

I strongly recommend that AMEDD commanders exercise great discretion in deciding whom to appoint as the Survivor Assistance Officer at the time of death of a military member of their command. I further recommend that MSC officers who are so appointed perform this merciful duty to the best of their ability and without complaint.

Honors

CPT George R. WARNICK was designated the Distinguished Honor Graduate of Class #4 of the Officer Basic Course. Joining Captain Warnick as Honor Graduates were CPT William H. PUCKETT, 1LT Wayne MORGES, and 2LT's James D. PARKER and Richard G. WALLIS.

2LT John H. CLARKE headed Class #3 of the Medical Materiel Services Management Course. Additional Honor Graduates of this course were CPT's Dennis ROSNICK, David K. ROYER and Richard C. SCHNEIDER, and 2LT Charles T. SAVIDGE.

Warmest congratulations to these fine young officers.

High Pharmacy Award

CPT Glidden N. LIBBY, the Chief of the Pharmacy Service at the U.S. Army Hospital, Fort Carson, was recently honored at the American Pharmaceutical Association Annual Meeting in San Francisco. Captain Libby was the recipient of the APH Military Section Literary Award. The award is given annually for the best published article in the field of pharmacy authored by a pharmacist in any of the Federal Services.

Captain Libby's award consisted of an inscribed plaque and a $500 honorarium. The award has been in effect for seven years, and this is the first time an Army pharmacist has won it. My warmest congratulations are extended to Captain Libby for this outstanding achievement.

Retirement of MSC Colonels

On behalf of all members of our corps, I extend best wishes for good health and continued success in the years ahead to all retiring MSC officers and their families. Following is a list of those MSC officers who recently retired while serving in the grade of colonel:

April 1971

COL Jerry H. CLARK
COL Robert E. COOPER
COL Stanley W. EGENSE
COL John A. HILCKEN
COL Richard S. RAND
COL William R. THOMAS
COL Howard C. LEIFHEIT

May 1971

COL Woodus A. CARTER
COL Gerald J. DORAN
COL Jack W. GWIN
COL Sam A. PLEMMONS
COL Herbert J. THOMPSON
COL Marvin A. WARE

June 1971

COL Jordan L. EPPERSON
COL Zane K. KING
COL John H. PAYNE
COL Kenneth N. PORTS
COL Charles R. WOLF, Jr.

Food for Thought

I am only one, but I *am* one;
I cannot do everything
But I can do something.
What I can do, I ought to do
And what I ought to do
By the grace of God, I *will* do.

MSC BRANCH
COL E. R. McCandless

Branch Organization

Name	*Position*	*Phone*
COL E. R. McCandless	Chief	36200 35460
LTC R. Webb III	Asst Chief	35460
MAJ C. W. Washington, Jr.	Education Coordinator; MOS Actions	35460
MAJ R. G. Black	CP & Asgmt Officer (Majors)	36200
MAJ T. E. Keller	CP & Asgmt Officer (Captains)	36200
MAJ J. R. Schlaak	CP & Asgmt Officer (Lt's & WO's)	36200

Address all mail to: OTSG-DA (MEDPT-MS); ATTI: (appropriate action officer); Washington, D.C. 20314.

Selectees for Graduate Training

Congratulations are the order of the day for the following named MSC officers who were selected for long-term civilian training during FY 72:

CPT Wayne C. AOKI, University of Hawaii.

MAJ Martin W. BARBOUR, Trinity University.

*CPT Paul F. BRENNER, Yeshiva University.

*CPT David G. BURLESON, Duke University.

MAJ Lloyd CHRISTIANSON, University of Arizona.

CPT Edward G. COLE II, Pennsylvania State University.

MAJ Kenneth J. DAMIAN, University of Florida.

MAJ David C. DANHOUSER, University of Wisconsin.

*CPT Alexander L. DOHANY, University of Florida.

MAJ Lloyd J. EASON, University of Oregon.

CPT Thomas E. FAHEY, University of Denver.

CPT Boyce Fields, Jr., University of South Carolina.
MAJ Barry E. FITZGERALD, Louisiana State University.
MAJ Robert B. FULTON, Florida State University.
CPT David D. GLICK, University of Indiana.
*MAJ Donald M. GRAYDON, University of California at Los Angeles.
MAJ Milton GRADY, University of Maryland.
CPT William R. HINSHAW, Auburn University.
CPT Roger E. HOLBERTON, University of West Florida.
*MAJ Ronald W. INTERMILL, University of Mississippi.
*MAJ Thomas A. JANKE, University of Iowa.
MAJ Donn C. JONES, St. Mary's University.
CPT Larry L. Jones, University of Oklahoma.
MAJ Richard B. JUDY, University of Indiana.
CPT James W. LeDUC, University of California at Los Angeles.
*MAJ Karl E. LONGLEY, John Hopkins University.
*CPT Andree J. LLOYD, University of Oklahoma.
MAJ John M. McLEAN, University of Minnesota.
MAJ Bruce T. MIKETINAC, University of Notre Dame.
CPT Robert K. OVEREND, University of the Pacific.
CPT Steven J. PORTER, Syracuse University.
*MAJ Howard T. PRINCE, University of Texas.
*CPT Frank X. QUINN, University of Chicago.
*MAJ Roy H. RENGSDORFF, Ohio State University.
MAJ Charles R. RITCHEY, Oklahoma State University.
MAJ Roger R. ROBY, Syracuse University.
LTC Alan SAMUELS, University of Florida.
*CPT Austin C. SCHLENKER, North Carolina State University.
CPT Patrick A. SCHLENKER, St. Mary's University.
MAJ Joel SEVERSON, University of Colorado.
CPT Vincent R. SHERMAN, Johns Hopkins University.
CPT John T. SOLOOK, University of Minnesota.
MAJ Marvin SPATZ, University of Michigan.
*CPT David B. Steen, Catholic University.
*CPT James R. TANSOR, Catholic University.
CPT Andrew R. TARTLER, University of Tennessee.
MAJ Sarah V. THOMPSON, West Virginia University.
CPT Kenneth W. VORPAHL, University of Cincinnati.
*CPT Edwin W. VAN VRANKEN, University of Denver.
MAJ David G. WILLIAMS, Syracuse University.
CPT William A. WRIGHT, University of North Carolina.

*Selected for doctoral training.

Applications for HCA, FY 73 (AR 350-219)

All individuals interested in applying for the Health Care Administration Course beginning in August 1972 are reminded that their applications must reach OTSG not later than 1 September 1971.

Normal prerequisites include (1) eight years active federal commissioned service, (2) credit for the AMEDD Officer Advanced Course, and (3) a bachelor's degree from an acceptable university or college. Furthermore each applicant should have a 2.7 grade-point-average (on a 4-point grading system) and a GRE score of 1000 or an ATGSB score of 500. Applications are not desired from those officers with less than eight years of service who wish to enter the program as "Early Starts."

AMEDD Personnel Management Course

Arrivng to find Washington under siege from peace demonstrators, 48 AMEDD personnel officers from around the world gathered for the opening session of the course on Monday morning, 3 May 1971.

Most visitors found an impediment to their travels that first morning when the bus scheduled to pick them up at their hotel was unable to arrive on time. But employing taxis and hitching rides, all arrived at the Forrestal Building no later than an hour past scheduled course opening time. Although there was talk of applying for hazardous duty pay, the course participants settled into the routine quickly and, by noon Monday, the planned activities were back on schedule in the classroom.

LTG Hal B. Jennings, Jr., The Surgeon General, opened the course via videotaped remarks, necessitated by his absence from the city on 3 May. In a hard-hitting challenge to the participants, General Jennings described the "new breed" of medical personnel officer. He is a far cry from the old stereotypical "pencil-pusher," who sat behind his desk and looked for ways to make life difficult for his "customers." Today's personnel officer gets out and gets to know the administrative problems of both patients and staff; finding ways to hep these customers" is the main objective. The Surgeon General said. WORSAMS and VOLAR both pose significant "people-problems" for the AMEDD, and General Jennings charged his personnel officers with anticipating such problems and advising medical commanders at all echelons of how best to minimize these effects.

In a strongly worded argument, General Jennings explained why personnel practices within the AMEDD were fundamentally different from the line personnel function, and he went on record as being committed to AMEDD retention of its own MSC personnel officers. That unique orientation and dedication to concerned patient care which sets the new-breed AMEDD personnel officer apart from his line counterpart also provides him with the signal ability to play one of the most vital roles in today's Army Medical Department.

MG Spurgeon Neel, Deputy Surgeon General, and BG Morrison, Chief, Medical Service Corps, both were able to speak to the course before catching a plane Monday evening for Europe. Other speakers were COL Robert Montague, Deputy Special Assistant for the Modern Volunteer Army; COL Lewis Huggins, Executive Officer, Directorate of Plans, Supply, and Operations, OTSG; and COL William J. Myers, Jr., Chief, Personnel Policies and Special Studies Office, Directorate of Personnel and Training, OTSG.

Monday evening, at the Bolling Air Force Base Officers' Club, course participants and OTSG staff members enjoyed cocktails and dinner before being treated to a particularly inspiring speech from the first MSC general officer and immediate past chief of our corps, BG William A. Hamrick, Ret.

Tuesday was devoted to enlisted personnel management activities with an address by COL B. M. Read, Deputy Director, Enlisted Personnel Direc-

torate, OPO, DA, and two workshops led by personnel from EPD and OTSG. One of the week's highlights came Tuesday afternoon when the group heard Dr. Gordon L. Lippitt of George Washington University discuss "The Personnel Officer's Role in Managing Change." Concluding the course's second day, the class divided into four discussion groups for the first of two 90-minute sessions during which common problem areas were explored.

On Wednesday, COL William R. Knowles, MSC, who is the Department of Defense Representative to MAST (Military Assistance to Safety and Traffic), told the students about the MAST program and the utilization of AMEDD and other aviators in several CONUS test-sites in furtherance of this dramatic and humanitarian program.

The rest of Wednesday morning was devoted to civilian personnel and unions, with presentations from William J. Schrader, Chief of Labor Relations Division, Office of Civilian Personnel, DCSPER, DA; and COL Gilbert L. Jacox, MSC, Director of Health Legislation Policy, Office of the Assistant Secretary of Defense, Health and Environment. Two workshops in various aspects of civilian personnel management were held before lunch. COL W. C. Luehrs, Executive Officer, OTSG, then spoke to the group and provided insight into the current operations of The Surgeon General's Office.

Officer Personnel Management became the day's topic on Thursday, when COL Floyd Baker, Director of Personnel and Training, OTSG, opened the morning session. Chiefs of the six AMEDD career branches within Personnel and Training formed a free-wheeling panel moderated by COL Charles J. Shively, MSC, Executive Officer and Chief of the Officer Personnel Division, Directorate of Personnel and Training, OTSG. Panel participants were COLs Suriano, DC; Bueschell, VC; McCandless, MSC; Wilson, ANC; Lieutenant Colonel Kiel, representing Colonel Mendez, MC; and Lieutenant Colonel Anderson, AMSC.

After a presentation on the Officer Efficiency Report system by LTC F. W. Craig, from DCSPER, DA, Colonel Baker moderated an AMEDD personnel actions panel consisting of Colonel Nystrom, Lieutenant Colonels McCain and Smith, and Mrs. Jo Ann Dow and Mrs. Jilane Burgess, DACs. Thursday afternoon was devoted entirely to "The Junior Officers' Command Problems: Drug, Race, and the Counter Culture." Four young MSC officers, CPTs William H. Duncan, Jr., Ft Belvoir, and Vincent M. Eitler II, Ft Meade; and Lts Peter G. Kramer, Ft. Sam Houston, and David W. Abbot, Ft. Carson, joined with senior officers from the Washington area in portraying the problems of today's young commander and in discussing various approaches to solutions. Dramatic situations were brought into focus by COL Ralph Morgan, Assistant Chief (Allied Sciences), MSC, and Social Work Consultant, along with Chaplain (COL) Thomas Harris, OTSG, LTC Sherman Ragland, MSC, Asst Chief, Social Work Service, Walter Reed General Hospital, and MAJ Jesse J. Harris, MSC, MSW-Candidate, University of Maryland, using the techniques of Psychodrama. The young MSC commanders furnished both practical and surprisingly mature suggestions as to how they would handle such situations in real life.

The final day of the course, Friday, saw Colonel Shively return to the lectern for presentations on (1) CPMIs (assisted by MAJ Robert E. Wright, Chief, CPMI Team, OTSG), and (2) Manpower Management (with COL

PERSONNEL MANAGEMENT COURSE: *Sitting:* COL K. D. Garis; COL W. B. Ledbetter; COL W. L. Ostby; COL J. A. Lapiana; COL F. G. Dickinson; COL E. R. McCandless, Course Director; COL R. C. Ferm; COL J. W. Hume; COL C. L. Franklin; COL D. O. Patrick; COL S. E. Akers. *Second Row:* MAJ J. P. Jones; MAJ T. R. Edwards; MAJ J. W. Vallandingham; CPT (P) J. T. McGibony; MAJ D. A. Lacey; MAJ R. Hahn; MAJ F. A. Eaton; MAJ G. E. Green; MAJ R. C. Fulton; LTC H. P. Edinger; LTC B. R. Bass; MAJ F. McDowell; MAJ M. G. Martin; MAJ K. J. Damian; MAJ R. N. Hansen; MAJ J. R. Wilson; LTC J. T. Madden; MAJ J. G. Gerukos; MAJ B. D. Smith. *Third Row:* MAJ L. C. McLeod; MAJ J. A. Newberry; MAJ C. L. McCauley; MAJ (P) J. P. Story; MAJ (P) G. H. Kelling; MAJ R. B. Heimendinger; LTC A. J. Troisi; MAJ R. R. Horn; MAJ E. M. Conway; LTC T. L. Trudeau; LTC R. A. Rada; MAJ R. H. Keel; LTC (P) J. E. Funk; LTC G. E. Chapin. *Not Shown:* COL R. H. White; LTC (P) C. J. McFarland.

Henry E. Maes, MSC, Chief, Manpower Management Group, Resources Management Office OTSG).

An update on Personnel Management systems was given by MAJ Michael Meuth, MSC, ADPS Division, OTSG, followed by a proposal for training AMEDD personnel officers presented by LTC Angelo Troisi, MSC, MFSS. Both OTSG staff and student participants were privileged to hear from the senior personnel officers from USARPAC, USAREUR, and USARV.

Giving the personnel status in their respective theaters were COL Charles L. Franklin, MSC, Executive Officer and Chief of Personnel for the Chief Surgeon, USARPAC; COL Darvin O. Patrick, MSC, Assistant Chief of Staff/Personnel and Administration, USA Medical Command, Europe; and COL Earl C. McSwain, MSC, Assistant Chief of Staff/Personnel and Administration, USA Medical Command, Vietnam, who just arrived home from that country the previous day.

After the four work groups completed their second 90-minute session, their respective student leaders presented findings and recommendations to the assembled class.

At the conclusion of the week, Course Director, COL E. R. McCandless, Chief, MSC Branch, Directorate of Personnel and Training, solicited suggestions and criticism on the course as presented, and COL Floyd Baker presented diplomas and made the closing remarks. Colonel McCandless expressed gratitude for the enthusiastic participation of all students and assured the group that the OTSG staff members involved had learned a great deal from them. Colonel Baker acknowledged the efforts of the MSC Branch in planning and presenting the course.

Change of MSC Assignments

April 1971

COL John C. CRIMEN, to William Beaumont GH.
LTC(P) Joseph REEVES, to OTSG, DA, Wash, DC.
LTC(P) Robert D. SHORT, to Hq, USA R&D Comd, Wash, DC.

May 1971

COL William X. SCHWARZ, to Letterman GH.

June 1971

COL Robert C. FERM, to USA Element, Hq, PACOM.
COL Theodore J. HALLADAY, to U.S. Army, Vietnam.
COL John A. LEE, to William Beaumont GH.
COL Ersel E. MARTIN, to Hq, Fourth U.S. Army dy w/CENA Ft. Sheridan.
COL William E. SCHLARB, to U.S. Army, Vietnam.
COL Wayne L. SIMPSON, to U.S. Army, Vietnam.
COL Reginald C. THOMAS, to OTSG, DA, Wash, DC.

July 1971

COL Luther G. H. BRUBAKER, to WRAMC.
COL Paul E. CEVEY, to AFIP, Wash, DC.
COL John R. CROSS, to Hq, U.S. Army Med Tng Cen, FSHT.
COL Francis G. DICKINSON, to U.S. Army, Europe.
LTC(P) Cowan J. McFARLAND, to OTSG, DA, Wash, DC.
LTC(P) John A. REBER, to Irwin AH, Fort Riley, KA
COL Charles T. TSAKONAS, to USAH, Fort Devens, MASS
COL George C. WELTON, to Letterman GH.

August 1971

COL Philip HOLTWICK, to 33d Field Hospital, USAREUR.
COL John W. NORTHING, Jr., to OTSG, Wash, DC.
COL Chester E. OVERMYER, to ODCS LOG, DA.
COL James J. YOUNG, to MACV.

September 1971

COL William L. BOST, to USA MERDL, Fort Totten, NY.
COL Harry L. GANS, to 1st Medical Group, FSHT.
COL James D. GRINDELL, to U.S. Army Advisory Group, Fort Lawton, WA.
COL Paul I. KAUFMAN, to Martin AH, Fort Benning, GA.
COL Paul S. MARSHALL to Darnall AH, Fort Hood, TX.
COL Clarence H. PIERCY, Jr., to USA CDC, MSA, FSHT.

Short Course Information

Thus far in the fourth quarter of this fiscal year, 363 MSC officers have attended AMEDD Professional Post-Graduate Short Courses listed in DA Pam 351-1. Courses planned during the first quarter of FY 72 are listed in the AMEDD Course Catalog of FY 72. Selected courses of interest to MSC officers include:

"Advanced Pharmacy Techniques"—Fitzsimons GH, 12-16 July 71 and 27 Sep-1 Oct 71.

"Current Trends in Army Social Work"—MFSS, 2-6 Aug 71.

"Medical Materiel and Services Management"—MFSS, 3 Sep-17 Nov 71.

"Patient Administration"—MFSS, 3 Sep-3 Nov 71.

Application procedures are in accordance with AR 350-219.

Help Wanted

Monrovia, Liberia, major or senior captain, 2120, advisor, two-year accompanied tour, no language requirement, fill needed ASAP.
Fort Kobbe, Canal Zone, lieutenant, special forces, 33506.
Fort Clayton, Canal Zone, lieutenant, special forces, 33506.
MAAG-USA Element JUSMMAT (Turkey), major 4490, no language requirement, fill needed ASAP.

MSC Miscellany

• Change 8, AR 621-5, is the latest change concerning general education development. Mainly, it allows up to 12 months for Warrant Officers to obtain an Associate Degree, or all officers to acquire a graduate degree . . .

• Army Medical Department Officer Undergraduate Degree Civil Schooling Program (AMEDD OUDP). This program allows an eligible officer to attend a civilian school to obtain an undergraduate degree. The allowable period of training is 24 months or less. Eligibility requirements and application procedures are outlined in DA Cir 351-22, 5 Feb 71.

• OTSG Cir 611-1, which outlines the policies regarding Medical Service Corps MOS classification, remains effective until further notice . . .

• Preference statements submitted from overseas areas should include DEROS and a CONUS phone number where the individual can be contacted upon return to the States . . .

• Save yourself a phone call . . . students in the AMEDD Officer Advanced Course who call the career branch about their forthcoming assignments prior to being interviewed by the team which comes from Washington during each class are ahead of the action. No assignments are made for these students until each has been

interviewed at Fort Sam Houston and the team has returned to OTSG. . . .

Senior MSC Personality of the Quarter

In his book *Excellence,* John W. Gardner states: "Some people may have greatness thrust upon them. Very few have excellence thrust upon them. They achieve it. They do not achieve it unwittingly, by 'doin' what comes naturally'; and they don't stumble into it in the course of amusing themselves. All excellence involves discipline and tenacity of purpose."

Epitomizing the dedication implied in Mr. Gardner's words, COL Jesse N. Butler inspires us to highlight his truly outstanding military career.

Born in Redmond, Ore., Colonel Butler attained a bachelor's degree in Pharmacy in 1939 and was commissioned a second lieutenant, USAR, shortly thereafter. He entered active duty on 1 July 1942 and has served continuously in increasingly important roles culminating in his present assignment as Chief of the Supply Division in The Surgeon General's Office.

Colonel Butler entered the medical supply career field in 1958 and has had the gamut of assignments offered in that field. Milestones during this period include Chief of the Army Medical Supply Support Activity, Brooklyn, N.Y.; Commanding Officer, USA Medical Supply Control Agency, USAREUR; Deputy Director for Medical Materiel, Defense Personnel Support Center, Philadelphia; and the Medical Materiel Director, Surgeon's Office, USARV.

Colonel Butler's academic credentials are equally imposing and reflect the discipline and tenacity of purpose to which Mr. Gardner referred. In 1955, Colonel Butler receiver a Master's of Business Administration from Harvard University. He is also a graduate of the Command and General Staff College and the Industrial College of the Armed Forces.

As one of the staunchest advocates of higher education, both civilian and military, Colonel Butler has set new standards for today's successful medical supply officer.

Known also for his compassionate and sensible approach to the utilization of 4490s, Colonel Butler (who was a personnel officer in his early career) maintains close contact with his people in the field and provides the strongest possible monitorship of the entire medical supply career field.

Among Colonel Butler's many awards and decorations are the Legion of Merit with oak leaf cluster and the Army Commendation Medal with oak leaf cluster.

MEDICAL ALLIED SCIENCES SECTION

COL Ralph W. Morgan

Farewell

Upon the occasion of my reassignment from the Office of the Chief of the Allied Science Section and Assistant Chief of the Corps, I wish to express my thanks to all of those AMEDD officers who have made possible the continuing growth in responsibility and achievement of Allied Science officers during my tenure of office.

I want to especially thank LTG Hal B. Jennings, Jr., The Surgeon General; MG Spurgeon Neel, Deputy Surgeon General; BG Manley G. Morrison, Chief of the Medical Service Corps; the consultants of the specialties within Allied Science Section: COL Harry McCurdy, MC, Audiology Consultant; LTC William G. Pearson, MSC, Entomology Consultant; COL Donald Hunter, MSC, Laboratory Sciences Consultant; LTC James E. Anderson, MSC, Nuclear Science Consultant; COL James E. Cassidy, DC, Military Community Oral Health, Manager Consultant; COL Robert Fels, Podiatry Consultant; LTC Charles A. Thomas, Jr., MSC, Psychology Consultant, and to all members of the Allied Science Section of the Medical Service Corps.

In every large medical organization there are always certain stresses that develop between executives who direct and coordinate the organization and the specialists who perform the complex scientific and technical duties that are the *sine qua non* of modern health care.

During my term of office, first under BG William A. Hamrick and more recently under BG Manley G. Morrison, I have found without exception that wherever problems have arisen relative to the employment or assignment of Allied Science officers that a successful resolution of these problems has been obtained through thoughtful consideration by the leadership of AMEDD of all factors involved.

Not the least of these factors has been the high level of technical achievement attained by the officers of the Allied Science Section. The resulting high *esprit* and prestige of the officers of the Allied Science Section of the Medical Service Corps is evident, not only in our current officer retention figures but in the increasingly high levels of scientific and administrative responsibility into which Allied Science officers in today's Army are being called to perform their professional leadership duties.

In the last analysis, the growth and development of the Allied Science Section of the Medical Service Corps cannot depend upon a simple bureaucratic rearrangement of responsibilities or even numbers of graduate degrees, but upon continuing, solid technical achievement in the accomplishment of the military medical mission. Since the Allied Science Section of the Army Medical Service Corps is firmly based on this concept and the leadership of the Medical Service Corps and the Army Medical Department is responsive to our needs and aspirations, I leave office confident that for the MSC Allied Science Section the best is yet to be.

Current Trends in Medical Laboratory Activities

This is a short course given each year at WRAIR and is scheduled for 4 to 8 October 1971. The course, which has always had enthusiastic attendance, is designed to present the most recent advances in laboratory procedures and management. Complete information is printed in the Army Medical Department Course Catalog, Fiscal Year 1972, Section III, paragraph 44, page 32. The officers who wish to attend this course should send in their application as soon as possible. Since the course starts in a few weeks, please notify the Laboratory Sciences Consultant, ATTN: MEDPS-CL, OTSG, DA, Washington, D.C. 20314. The Autovon Number is 223-6185.

Application for Laboratory Officer Training

The next Blood Bank Fellowship course is scheduled for 1 July 1972 to 30 June 1973. Descriptive information about the course may be found in the Army Medical Department Course Catalog Fiscal Year 1972, Section II, paragraph 6, page 5. Three Army officers will be selected for the course which is given at the U.S. Army Medical Research Laboratory, Blood Transfusion Division, Fort Knox, Ky. The fellowship will be awarded on a best-qualified basis and waivers may be granted for field grade officers. Applications for the course should be received by OTSG not later than 31 December 1971.

The next Medical Technology Course, which prepares MSC officers for MOS 3314, Clinical Laboratory Officer, will be held at Walter Reed General Hospital from 1 July 1972 to 30 June 1973. The course is approved by the American Medical Association and the American Society of Clinical Pathologists and, ordinarily, graduates of the course do not go to their next assignment until after they take the Registry Examination for MT (ASCP) certification usually given in mid-July.

Descriptive information about the course may be found in the Army Medical Department Course Catalog, Fiscal Year 1972, Section II, paragraph 12, page 8. This paragraph lists in detail the prerequisite college courses needed by all applicants.

The complete requirements for application for the course are described in the Army Medical Department Course Catalog and in AR 350-219. Please note that applicants must include an approved evaluation of their college transcript. The evaluation costs $5 and may be obtained by forwarding an official transcript of college credits to the Board of Schools, American Society of Clinical Pathologists, 710 South Wolcott Avenue, Chicago, Ill. 60612. Applicants for the course should be received by OTSG not later than 31 December 1971.

American Registry of Certified Entomologists

The Entomological Society of America announced 12 February 1971 the establishment of the American Registry of Certified Entomologists. This action, the result of an intensive 10-year study, is viewed as a major step forward in a program concerned with the well-being of man and his environment.

There is a clear and present need for a national certifying body to identify individuals qualified to provide technical service to the public in entomologically related activities. New laws governing pest management, restrictions as to choice and use of pesticides, prescription programs, and increasing pressure to permit only qualified individuals to engage in certain pest control programs are examples of activities requiring the identification of certified entomologists. Those engaged in sales of pesticides, those who have the role of pest control advisor, those who render special services including identification, consultation, marketing of biotic agents, and others who need special training and competence can now be registered in their professional specialty.

In announcing its Registry, the Entomological Society of America outlined a vigorous program of education and experience needed to qualify a person for certification. Required will be various combinations of major study in entomology with years of experience as a practicing entomologist. Initially 15 classifications are available including such categories as agricultural entomology, physiology, toxicology, medical and veterinary entomology, regulatory entomology, pest management, pesticide research, and urban entomology.

This program is designed to identify specialists with extensive training and proven technical ability capable of providing service to the public.

Army Medical Entomology Training Course

The biennial Army Medical Entomology Training Course will be conducted 18 through 22 October 1971 at Walter Reed Army Medical Center, Washington, D. C.

Purpose of this course is to bring Army Medical Entomologists up-to-date on recent developments in military entomology and to provide a forum for the exchange of ideas and experience from the various segments of the medical entomology program.

Fund limitations and other considerations will make it impossible for all entomologists to attend the course. Those selected will be notified so it will not be necessary for any individual to apply.

The Audiologist and the Army

The Army's interest in the hearing-impaired soldier dates from the years of World War I, when the rehabilitation of active duty personnel with hearing problems was conducted by 11 teachers at the Lipreading School of General Hospital No. 11, Cape May, N. J. The lipreading course lasted from six weeks to three months, and 108 hard-of-hearing soldiers completed the course.

During World War II, the Army faced the problem of rehabilitating thousands of returning hearing-

impaired soldiers. This necessitated the development and operation of three aural rehabilitation centers, located at Hoff General Hospital, Santa Barbara, Cal.; Borden General Hospital, Chickasha, Okla.; and Deshon General Hospital at Butler, Pa. In contrast to the few soldiers who underwent lipreading during World War I, some 10,000 soldiers were given aural rehabilitation between 1943 and 1946. In addition, hearing aids were issued to a large number of these patients.

After World War II, the Army consolidated the clinical audiology services into one major center at Walter Reed Army Medical Center. During the 20-year period from 1946 to 1966, the Army Audiology and Speech Center at Walter Reed was the only designated audiology center in the Army. Other hospitals had audiometric equipment, and some utilized personnel with training in Audiology to carry out their hearing tests. However, these individuals carried other Military Occupational Specialties since none existed for the audiologist.

The MSC Military Occupational Specialty (MOS) for audiology was formally requested in June 1964. Approval was granted by the Army Surgeon General in July 1965, with official publication of the MOS Code 3360 appearing in Army Regulations in January 1966. As mentioned, for many years prior to this date, noncommissioned and commissioned Army personnel had been performing various types of audiology services but were not assigned to any specific category related to hearing measurement.

The introduction of an audiology officer specialty program in the Army has permitted a decentralization of audiology services to larger Army Hospitals in the United States (CONUS), Europe, Hawaii and Japan.

Currently there are 18 audiology officers on active duty. Two of these officers have been granted leave to participate in an Army Educational Program available to career-oriented officers.

Audiologists and Speech Pathologists Gains and Losses

CPT Karl W. Hattler has accepted a position as Director of Audiology and Speech Pathology at the Lovelace Clinic, Albuquerque, N. M.

CPT Dick Arieto has left the military and the Army Environmental Hygiene Agency, Edgewood Arsenal and will be pursuing further graduate training.

The services of two CPTs Kelly in the Army Audiology program in Germany were reduced to one recently due to the anticipated addition to their family of a little Kelly.

CPT Brian E. Walden (Ph.D., Purdue University) has been assigned to the Army Audiology and Speech Center, Walter Reed General Hospital.

1LT Thomas M. Helfer (M.A., Our Lady of the Lakes College) is the new Chief of Audiology at Madigan General Hospital, Fort Lewis, Wash.

1LT Jeffery Goldstein (M.A., University of Illinois) and 1LT John H. Elmore (M.A., Northwestern University) are currently attending the Medical Field Service School at Fort Sam Houston, San Antonio, Tex. They will be assigned to the Army Environmental Hygiene Agency, Edgewood Arsenal Md., and Fort Jackson, S. C., respectively. We welcome these new officers aboard.

Army Pays Bill for ASHA Certification of 3360's

AR 40-219 effective 15 February 1970 provides authorization of fees and necessary travel costs for MSC Officers to get professional certification in the American Speech and Hearing Association. In order to be elegible an officer must:

- Be on active duty.
- Arranged for and be accepted for examination for certification.
- Have at least two years active duty remaining after reimbursement of certification fee.
- If stationed overseas, have sufficient time remaining to permit completion of the standard tour for the area of assignment.
- An officer whose service agreement has an earlier ETS than the two years required may request further active duty under AR 125-215.

Expansion of Audiology, Speech Pathology Sections at Fitzsimons

The Audiology and Speech Pathology Sections at Fitzsimons General Hospital, operating as a paramedical service under the Otolaryngology Service, have recently expanded their professional staff.

Dr. Darrel L. Teter is Chief of the Speech and Hearing Sections and in charge of the Research Division. CPT Carl F. Loovis is Director of Audiology. Mrs. Jan Redmond has been added to the staff as Director of Speech Pathology, and Miss Susan Slibeck has joined the staff as an audiologist.

Mike Koskuc, teacher of deaf education, remains with the staff as director of the acoustically handicapped school. The clinical staff also includes two part-time speech clinicians: Louis DeMaio and Larry Friedman.

Clinical services are available to all active duty military personnel and their dependents as well as for retired personnel located in the area. Patients are seen on both an outpatient and in-patient basis. The staff also provides an active teaching program for military residents and graduate students in the field of speech and hearing from the local universities.

Clinics at Letterman Approved by ABESPA

The Auditory Evaluation and Treatment Clinic and the Speech Pathology Clinic at Letterman General Hospital have been approved under the interim standards by the Professional Services Board of the American Boards of Examiners in Speech Pathology and Audiology.

Dr. John W. Keys, Chairman of the Professional Services Board offered his congratulations to CPT Mark McDowall and the two newly registered clinics. It is hoped that other military Audiology and Speech Pathology Clinics will undergo similar efforts to obtain registration.

Services at Tripler and Fort Dix

CPT Bruce (Buss) Rappaport has initiated military audiology services, which include the issuing of hearing aids, at Tripler General Hospital, Hawaii.

Fort Dix, N. J., is the first Army basic training center to have a military audiologist, 1LT David Mann, who recently completed a master's degree in audiology at Vanderbilt under Army auspices. The services of these new officers will greatly reduce the need for expensive medical evacuation of aurally impaired servicemen.

Army Auditory Evaluation, Treatment Clinics

The Audiology Section at Letterman General Hospital, headed by CPT Mark McDowell, and at Madigan General Hospital, headed by CPT Ronald Reiter, have been added to the list of Army Auditory Evaluation and Treatment Clinics.

Plans are being made to convert these smaller clinics into actual evaluation and treatment centers with the addition of offices, classroom, equipment testing facilities, waiting area, supply area, and additional Industrial Acoustic Corporation test suites. Other facilities which have previously been designated as Army Auditory Evaluation and Treatment Clinics are: Army Audiology and Speech Center, Walter Reed General Hospital; Brooke General Hospital, Fort Sam Houston, Tex.; 2nd General Hospital, Landstuhl, Germany; Fitzsimons General Hospital, Denver, Col.; and Tripler General Hospital, Honolulu, Haw.

All of these centers either have or soon will have the capabilities for conducting auditory examinations for profiles, separation or retirement, special auditory tests, hearing aid evaluations, and for providing for procurement and issurance of hearing aids and earmolds.

Army Audiology, Speech Center Renovated

The Army Audiology and Speech Center is located in the Forest Glen Annex of Walter Reed General Hospital, several miles north of the main hospital.

Since the center was converted from a dairy barn in 1946, there had not been any complete major revisions. Lighting, ventilation, heating, flooring, and testing facilities were less than adequate. The need for renovation and remodeling was further highlighted when heavy equipment was moved in to begin construction on the new commissary and PX to be located across the street.

Because of the noise, testing was interrupted, thresholds were difficult to measure, and therapy sessions were a mass of confusion. To alleviate this problem, the Army initiated extensive renovation and remodeling. The current renovation was directed toward the Hearing Evaluation Section, Aural Rehabilitation Section, administrative offices, and the Earmold Laboratory.

All of the double-wall suites in the Hearing Evaluation Section received new soundproof liners. An additional double-wall suite was also added to the Hearing Evaluation Section offering a potential increase in patient care of 25 per cent. With the new changes, the audiologists can carry out any audiological diagnostic test available for determining possible site of lesion. The Army Audiology and Speech Center is the most complete diagnostic and rehabilitative center in any branch of the services.

Change of Social Service Consultants

LTC Joseph Reeves, MSC, has replaced COL Ralph W. Morgan, MSC, as Social Service Consultant, Professional Directorate, Office of The Surgeon General. COL Reeves had been assigned as Chief, Social Work Branch, United States Army Correctional Training Facility, Fort Riley, Kan. He is on the current promotion list and has a doctoral degree from Washington University of Saint Louis.

Under the capable guidance of COL Morgan, the Army social work program progressed and flourished. A high quality of social work practice within medical and psychiatric settings has been maintained. Army Community Service programs have been developed and implemented. Social workers are now actively engaged in the Army correctional program. Teaching programs have been expanded and refined. Social workers have been assigned to special areas where their professional skills and knowledge can be applied productively.

The present challenge is to continue to increase social work service to the Army. This demands new ideas, new ways of looking at old problems, fresh thoughts and high professional standards. The 274 social workers in the Army can meet this demand.

Department of Defense Race Relations Institute

Three Medical Service Corps colonels have been assigned to the newly established Defense Race Relations Institute which will be activated at a station to be designated in July 1971. COL Edward F. Krise has been appointed Director, COL Ralph W. Morgan has been designated Director for Instruction, and COL Albert Kilby is to be Assistant Director of Instruction.

According to its mission, the Defense Race Relations Institute will conduct training for Armed Forces personnel designated as instructors in race relations, develop doctrine and curricula for education for race relations, conduct research, perform evaluation of program effectiveness and disseminate educational guidelines and

materials for utilization throughout the Armed Forces. The Defense Race Relations Institute is a field activity of the Office of the Assistant Secretary of Defense, Manpower and Reserve Affairs, and subject to the policy guidance of the Defense Race Relations Education Board.

OPTOMETRY SECTION

COL Herbert J. Thompson

Key Assignment Changes

LTC Gene M. BOURLAND returned from RVN and has been assigned as the Chief of the Optical Laboratory at Fitzsimons General Hospital.

LTC Robert J. BRYANT will be attending the Command and General Staff College after vacating his present position as Chief of the Optometry Section, Brooke General Hospital.

LTC Richard F. JELLERSON has departed from his previous assignment as the Chief of the Optical Laboratory at Fitzsimons General Hospital and is now the Chief of the Optometry Section at Brooke General Hospital.

LTC Arthur B. GIROUX has returned from his assignment as the optometry consultant for Vietnam and is now the Chief of the Optometry Section, Tripler General Hospital.

LTC Frederick VAN NUS has left as Chief of the Optometry Section at Tripler and is now the RVN Optometry Consultant.

LTC Robert P. COTTER has been reassigned to Einsiedlerhof, Germany, after completing his duties as the Chief of the Optical Laboratory in Okinawa.

LTC Charles T. HUDGINS will complete the resident requirements for Command and General Staff College and then report to Fort Benning as the Chief of the Optometry Section.

MAJ Robert H. PINSON has been reassigned from the Army Environmental Hygiene Agency to Okinawa as Chief of the Optical Laboratory.

Retirements

LTC Donald L. WILKES retired the end of March from Letterman General Hospital after completing over twenty years of excellent service to his country and military optometry.

LTC Robert J. WELLS retired the end of May at Ft Rucker, Alabama, after completing over 24 years of devoted service to his country and Army optometry.

We thank these two fine officers and wish them the best of health and happiness in the years to come.

Optometric Triage

Numerous installations have instituted visual screening programs in an attempt to provide efficient optometric care to an ever-increasing patient load with limited professional resources.

These programs have shown the worth of such an approach and consequently a model program is being staffed through The Surgeon General's Office at present. This model will serve as a guide in an attempt to standardize the approach to the problem of excessive backlog and waiting time. It is realized that each installation has unique requirements and will have to tailor their visual screening program accordingly, but certain facets of all of them can be similar.

The use of ancillary personnel, screening criteria and triaging optometry officers have proved to be an effective tool for offering equitable care to those in greatest need as soon as possible and deferring a significant percentage of the dependent and retired patient load without jeopardizing their visual health.

Change in Optometry Organizational Structure

COL Herbert J. Thompson retired on 21 May 1971 after culminating an outstanding military career as the Chief of the Optometry Section of the Medical Service Corps, Optometry Consultant to The Surgeon General and an Assistant Chief of the Medical Service Corps.

As of 1 June 1971, COL Henry E. Maes was assigned to the positions of Chief of the Optometry Section of the Medical Service Corps and an Assistant Chief of the Medical Service Corps. In his position as Chief of the Optometry Section, he will monitor all Army optometry matters and the assigning of career Army optometrists. Consequently, all correspondence relating to these matters, as well as career development inquiries, should be directed to him.

As an Assistant Chief of the Medical Service Corps, he represents the Chief of the Corps at numerous optometric and military functions. COL Maes will continue to serve as the Chief of the Manpower Management Group of The Surgeon General's Office in addition to his newly acquired optometric positions.

LTC David E. Johnson has been assigned to OTSG as the Optometry Consultant. In this capacity, he is serving as an advisor to The Surgeon General's Staff as well as to optometry officers in the field and, in coordination with COL Maes, is assigning newly acquired optometrists.

PHARMACY, SUPPLY AND ADMINISTRATION SECTION

COL Andrew J. Colyer

Comptroller Career Field

Nephtune Fogelberg, who served as Comptroller to The Surgeon General since the position was established, retired at the end of April 1971.

Mr. Fogelberg was born in Logan, Utah, on 9 August 1904, and attended school there. He graduated with honors from Utah State University in June 1927. He then entered Harvard Graduate School of Business in September 1927 where he received a Master's in Business Administration in June 1929.

Mr. Fogelberg's Federal career began in 1929 when he went to work for the United States Department of Agriculture as an Agriculture Economist

His career with the Army Medical Department began on 2 November 1942 when he was commissioned as a first lieutenant in the Sanitary Corps, one of the forerunners to the present Medical Service Corps. Mr. Fogelberg's first military assignment was as Fiscal Officer in the Medical Department Fiscal Branch Office, Chicago Medical Depot. Later he was transferred to the Office of The Surgeon General where eventually he was promoted to major and appointed Director of the Fiscal Division.

Upon release from the Army in May 1946, Mr. Fogelberg remained in The Surgeon General's Office in a civilian capacity as Director of the Fiscal Division. The Fiscal Division was reorganized as the Office of the Comptroller in June 1952 and Mr.

Fogelberg occupied this position until his retirement.

A formal retirement ceremony was held at the Office of The Surgeon General on 29 April. At this ceremony, Lieutenant General Hal B. Jennings, Jr., the Army Surgeon General, presented to Mr. Fogelberg the Exceptional Civilian Service Award. This award is the highest Department of the Army award conferred on Army civilian personnel. General Jennings also pinned an orchid corsage on Mrs. Fogelberg in recognition of her support to her husband during the years he was associated with the Army Medical Department.

Mr. Fogelberg was one of the best known and most respected persons within the Army Medical Department. There are few senior officers who do not know him and fewer still who do not know him by reputation. He is the one person most responsible for the outstanding financial support the Army Medical Department has received for many years. Without this support, the level of medical care available today would not have been possible.

Medical Supply Career Field

Medical supply officers continually compete with other members of the MSC for promotion and for advanced military and civilian training. Competition for promotion is intense. An outstanding performance record may not be a sufficient basis for selection to the next higher grade. The promotion board may also consider whether the officer has an advanced academic degree or whether he has completed the Command and General Staff College Course or a comparable military course.

This means each medical supply officer must seek opportunities to advance his career. Qualified officers should seriously consider applying for academic training which leads to a master's degree in hospital administration or business administration. Graduation from the Health Care Administration Course is an excellent method for medical supply officers to gain an advanced degree and increase their performance capability as supply officers.

Senior Medical Supply Officers should continually counsel and assist younger officers to pursue courses of action which will enhance their careers and promotion potential.

All medical supply officers and officers interested in becoming supply officers should read the following articles in previous newsletters.

Volume 1, No. 1, Pages 18-19
Volume 1, No. 2, Pages 25-26
Volume 1, No. 3, Pages 21-22
Volume 2, No. 1, Page 32
Volume 2, No. 2, Page 29

Normally, requests for academic and military training and other personnel matters are submitted in accordance with appropriate DA and OTSG instructions. In the event additional assistance is required, queries may be submitted to COL Jesse N. Butler, Chief of the Supply Division, Directorate of Plans, Supply, and Operations, Office of The Surgeon General, Washington, D.C. 20314.

Operations Career Field

LTG Hal B. Jennings, Jr., MC, opened the fourth annual Professional Postgraduate Short Course, "Current Problems and Trends in Medical Plans and Operations" on 26 April 1971 at Fitzsimons General Hospital, by dedicating the Quade Memorial Conference Center.

The conference center, named after BG Omar H. Quade, who commanded Fitzsimons General Hospital from May 1942 until his retirement in August 1948, provided the ideal location for the high-level course which continued through 30 April 1971.

The purpose of the course was to provide a forum for senior Army medical plans and operations officers on current programs, policies, problems and trends at major commands and Department of Army and their impact on the Army Medical Department plans and operations.

Each broad area includes concepts, doctrine, studies, systems application and research projects associated with the organization for delivery of all facets of health care.

It was presented at the postgraduate level and the target group was the senior AMEDD officer population. To provide a forum for the discussion of current and projected problems and projects by officers involved in medical planning, attendees included selected members of ther AMEDD corps, representatives of other military medical services and MSC officers in other career fields whose contemplated or actual assignment is related to plans and operations functions.

The professional conference was highlighted by the extremely impressive list of guest speakers and attendees. After the dedication of the new Center by General Jennings, BG Manley Morrison, Chief of the Medical Service Corps, delivered the keynote address, "Challenges for the 2162."

COL Robert M. Montague, Deputy Special Assistant for the Modern Volunteer Army, presented the impact of VOLAR on military plans and operations. The United States Navy and Air Force medical services were represented by CPT Theodore H. Conaway, MSC, and COL Elmer F. Gillespie, MC, respectively. COL Lewis H. Huggins, Course Director and Plans and Operations Consultant to the Chief of the Medical Service Corps, brought all attendees up-to-date on the status of the Worldwide Organizational Structure for Army Medical Support (WORSAMS). Conference attendees were also brought up-to-date on problems and trends in Western Pacific, USAREUR, USARAL and US Army Forces, Southern Command.

A discussion of the Army Force Development Program by BG F. J. Kroesen, Director of Manpower and Forces, Office of the Assistant Chief of Staff for Force Development, highlighted the second day of the conference. Other key presentations on the second day were the Conceptual Design for the Army in the Field (CONAF) by COL Robert E. John-

son and "Problems and Trends of CHAMPUS" by COL Grover C. Kistler, the executive director of OCHAMPUS.

BG Thomas J. Whelan, Jr., MC, Special to The Surgeon General for Medical Corps Affairs, discussed in detail the "Concept of the Physician's Assistant" and led off the third day of the conference. He was followed by LTG Joseph M. Heiser, Jr., the Deputy Chief of Staff for Logistics. General Heiser discussed the DCSLOG areas of interest as they relate to The Surgeon General's activities. His presentation was extremely well received and constituted his second consecutive annual presentation at this conference. General Heiser remained to hear COL Jesse N. Butler, Chief of Supply Division, discuss The Medical Logistical System —Worldwide.

The fourth day of the conference was highlighted by presentations given by LTG Walter T. Kerwin, Jr., BG Louis J. Hackett, Jr., MC, BG Richard R. Taylor, MC, and BG Robert Bernstein, MC. General Kerwin discussed the current major personnel problems and programs and how they impact on the AMEDD's plans and operations. He was followed by General Hackett who discussed the resources outlook for the Army Medical Department. General Taylor's topic encompassed the "Highlights of Medical Research and Development." General Bernstein, Command Surgeon, Military Assistance Command, Vietnam, presented a detailed review of the medical planning associated with the drawdown of U.S. forces in Vietnam.

LTC Joseph R. Cataldo, MC, opened the final day of the conference with a well-received report of the medical planning for the raid into North Vietnam attempting to rescue U.S. prisoners of war at Son Tay. Colonel Cataldo was followed by LTG Richard G. Stilwell, the Deputy Chief of Staff for Military Operations. General Stilwell's stimulating discussion of the "Planning for the Army in the 70's," with special emphasis on the impact of the Nixon Doctrine, was fitting topic for the final day of a conference of Army medical planners and operations officers. COL Richard H. Ross, MC, Director of Plans, Supply and Operations, Office of The Surgeon General, gave the closing remarks which culminated the very successful and informative week.

Most of the presentations were preserved on video tape and are available upon request from the course director. A number of the presentations were classified and therefore will require special consideration before being further disseminated. A copy of the week's agenda indicating classified and unclassified presentations is available by writing to the Course Director, COL Lewis H. Huggins, MSC, Office of The Surgeon General, ATTN: MEDDD, Forrestal Building, Room 6A057, Washington, D.C. 20314.

Notes from the Aviation Consultant

MSC quotas for primary rotary wing flight training have been reduced to 35 for Fiscal Year 1972. As a result, applicants will be placed on a waiting list and placed in classes as quotas are available.

Initiation of the flight excusal program and reductions in required flying hours for certain categories of aviators have created a significant amount of confusion. To clarify this situation, the following information is quoted:

"The basic ground rule in determining your category pertains to *duty* MOS's. Aviation related *duty* MOS's are identified as 1980 thru 1987; 2518; 7423; 7424.

All duty MOS's prefixed by '6'— such as 6423.

The other criteria is that of *rated* military service. This is computed from the date you received your initial rating as an Army aviator. All periods concerning breaks in service and indefinite suspension from flight status are deducted.

Now that you have determined your duty MOS and length of time served as a rated military officer, you can determine which category relates to you.

Category 1. Currently rated aviator with over 15 years flight service in a non-aviation MOS. You are *prohibited* from combat readiness flying but will draw flight pay provided you pass your annual physical. You may perform pilot duties on administrative or service missions provided you satisfy command proficiency and currency requirements, complete the annual written examination and hold a current instrument rating if the mission calls for that qualification. You may maintain your instrument rating provided the necessary hours are flown on service or administrative missions.

Category 2. Currently rated aviator with over 15 years flight service in an aviation MOS (include prefix 6). You will maintain proficiency in accordance with AR 95-1 to include 80 hours annually (15 night, 20 cross-country and 20 instrument). You must complete annual physicals, instrument renewals and annual written examinations. However, you no longer are required to have 4 hours monthly for pay purposes. Only annual and semi-annual flight requirements apply.

Category 3. Rated aviator with less than 15 years flight service in an aviation duty MOS. All requirements of AR 95-1 apply plus annual physical and annual written examination. You are also required to fly 4 hours per month for pay; however, the flight accrual program which allows you to accrue five months' flight time ahead is still in effect. (80 hours annual/30 hours semi-annual)

Category 4. Rated aviator with less than 15 years flight service in a non-aviation duty assignment (includes students) will meet requirements of their major command. Current regulations delegate to major commanders the authority to reduce annual flight minimums for aviators in this category if funds and/or aircraft are not available. USCONARC has reduced annual minimums in this category to 48

hours with no semi-annual requirements, no cross-country, night or instrument requirements and no requirement for instrument renewals. This is not Department of the Army policy, so you must insure that you comply with the policies of the major command. These policies are also subject to change each fiscal year."

There are a few important factors that must be considered. Foremost is the fact that the reduction to 48 hours per year does not meet the requirements for full combat proficiency and is instituted *only* when funds, aircraft or other factors preclude maintaining full proficiency. By no means is this intended for the personal convenience of the individual.

The second consideration is the goal of AMEDD aviation in striving for an all-weather capability and a desire that AMEDD aviators be the best qualified professionals in the aviation field. This can only be accomplished through the personal initiative of every medical service aviator.

Instrument examiners are our greatest asset in achieving and maintaining a high degree of professionalism. They are not trained for the sole purpose of renewing instrument qualifications or for taking the difficult flights. They are, in fact, the top professionals in the instrument flying field and as such must teach constantly in order to raise the standards of our AMEDD pilots, both warrants and commissioned. To accomplish this, the examiner must be placed in a position where he can best do the job and be afforded complete command backing. Every accident that occurs and every AMEDD aviator who is injured or killed in an accident is a direct reflection on the chain of command that permitted it. The blame rests not on the pilot but on the maintenance officer who did not make the final inspection or the commander who was too timid to ground an aviator that lacked proficiency. We want professional medical aviators leading professional aviators. The non-professional is a hazard to our mission and should seek another career field.

Pharmacy Career Field

The sixth biennial Army Pharmaceutical Service Management Short Course was conducted at the Walter Reed Army Institute of Research (WRAIR), Washington, D.C., during 3-7 May 1971.

Fifty-nine active duty Army officers attended this year's course. This represented the largest such group ever assembled. Also attending were three Air Force officers and two Army Reserve officers on active duty for training.

The course of instruction is authorized under the provisions of Department of Army Circular 351-10. Its purpose is to maintain the professional and administrative competence of officers responsible for providing hospital pharmacy support within the worldwide Army Medical Department (AMEDD) health care system.

Genesis of the current excellence within Army hospital pharmacy can be traced to the initiation of a hospital pharmacy post-graduate training program in 1957. Impetus for developing the program was provided by the Pharmacy Consultant to The Surgeon General, at that time, COL William L. Austin, MSC. Today's training involves attendance for one year at an approved civilian graduate school which offers a master's degree in hospital pharmacy, followed by a one-year residency training program in hospital pharmacy accredited by the American Society of Hospital Pharmacy.

The post-graduate program has produced 35 Medical Service Corps officers with master's degrees in hospital pharmacy. The impact of the program is evidenced by the agenda of this year's Management Course.

The scope of subject material under discussion reflected a degree of professional sophistication and awareness, far beyond that of previous meetings. This was most apparent when one reviewed the faculty roster. With few exceptions. professional papers were presented by Army officers currently involved in the practice of hospital pharmacy.

Topics of discussion included: (1) Methods for developing, equipping, and implementing improved outpatient prescription dispensing facilities; (2) personnel, space, training and equipment requirements for a pharmacy sterile products program; (3) pharmacy service implementation of an in-patient unit-dose medication system; (4) considerations for developing and conducting an accredited Army hospital pharmacy residency training program; and (5) the maintenance of internal pharmacy service quality control procedures.

In addition, attendees were updated on current programs involving the direct participation of Army pharmacists in: (1) the formulation of radiopharmaceuticals; (2) the National Academy of Science/National Research Council (NAS/NRS) drug efficacy studies; (3) development of Essential Characteristics, and subsequent quality control, for pharmaceuticals produced by the Department of Defense; (4) adverse drug reaction reporting; (5) the work of the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS); (6) the Army Investigational Drug Review Board.

Instruction for this year's total course program involved the participation of a significant number of company and junior field grade officers. This was an extremely "healthy" situation, reflecting the ever-increasing relevancy and professional maturity of Army hospital pharmacists.

Medical Intelligence Career Field

COL William B. O'Neill will complete his present assignment in July 1971 and is returning to duty with the North Atlantic Treaty Organization (NATO), in which he served before coming to the Office of The Surgeon General (OTSG) in 1967.

He will first attend the NATO Defense College in Rome, Italy, the first MSC officer to do so, and will then be assigned as Allied Forces Southern Europe (AFSOUTH) Liaison Officer to the Supreme Hellenic Armed Forces Command in Athens, Greece.

COL Reginald C. Thomas, who since June 1969 has been assigned to Brooke General Hospital as Chief of Microbiology and Administrative Director of the American Society of Clinical Pathology School of Medical Technology, will be the new Special Assistant to The Surgeon General for Intelligence and Chief of the Medical Intelligence Office, OTSG.

Colonel Thomas, who holds a BS degree in biology from Northeastern University and an MS degree in Bacteriology from Tufts University, has done additional postgraduate study in the health sciences at Duke University and the Harvard School of Public Health.

In 1943 he was commissioned in the Medical Administrative Corps at Camp Barkley, Tex., and assigned to the Asiatic-Pacific Theater, where he served in the Philippines until 1946. Returning to civilian life, he was appointed to the faculty of Northeastern University and remained there until his recall to active duty in 1952.

Since then he has served successively as Chief of Microbiology at the Third U.S. Army Medical Laboratory, Second U.S. Army Medical Laboratory, Tripler General Hospital and Brooke General Hospital. While assigned to Germany, he served as executive officer of the U.S. Army Europe Medical Laboratory.

Colonel Thomas has been active in civic and fraternal organizations. He is a 32-degree Mason and a member of the Shrine. In 1969 he was awarded the DeMolay Cross of Honor by the International Supreme Council, Order of DeMolay. His professional organizations include Sigma Chi, a national honorary scientific society; the American Society for Microbiology; and the American Public Health Association.

The Thomases have a son, Royce, completing his sophomore year at North Georgia College.

SANITARY ENGINEERING SECTION

COL Bernard L. Goldstein

Personnel Notes

CPT Philip H. PERKINS was assigned to the Environmental Engineering Branch, OTSG on 1 March 1971. Captain Perkins, the first Military Environmental Sanitarian assigned to the Environmental Engineering Branch, is a graduate of the University of Massachusetts with B.S. and M.S. degrees in Public Health. He is a Registered Sanitarian with the Commonwealth of Massachusetts and the National Environmental Health Association.

LTC Henry T. MILLER, now at First Army Headquarters, will soon be on his way to be the Chief of the USARPAC Environmental Health Engineering Service (EHES). This EHES, located in Okinawa, is the newest one in the Army and provides theater-wide environmental engineering services to all elements of USARPAC. Colonel Miller replace LTC Davy Kneessy who moves to the Medical Field Service School.

In June, MAJ William W. PALMER, Jr. departs Sixth Army Headquarters for Vietnam where he will assume command of the 20th Preventive Medicine Unit.

Recent promotions include Wemdell L. WARD to LTC and Kenneth W. VORPAHL to MAJ.

Major Vorpahl, Chief, Fifth Army EHES, returns to graduate school at the University of Cincinnati this fall for a master's degree in industrial hygiene. Major Ferd W. McEntire moves across the post from the M.F.S.S. to Fifth Army Medical Laboratory to become Chief of the EHES.

Other officers off to graduate school this year include MAJ Karl E. LONGLEY to John Hopkins University for a Ph.D., MAJ John McLEAN and CPT John T. SOLOOK to the University of Minnesota for a MPH, and CPT Vincent SHERMAN to John Hopkins University for a MPH.

CPT James O. BRYANT, Jr. has just moved into a key R&D position with Mobility Equipment Research and Development Center at Fort Belvoir. He fills the position vacated by MAJ LeRoy H. REUTER who moved to U.S. Army Medical R&D Command.

Newly Commissioned Officers and their next duty station are:

CPT Daniel L. STONEBURNER—USAEHA.

1LT Phillip R. FRYE—USAREUR.

1LT James R. GATES—Fort Meade, Md.

1LT Ross L. KROLL—USAREUR.

1LT Lester Y. PILCHER—Korea.

1LT Gary A. THOR—USAEHA.

1LT Gregory A. WILDERMAN—First Army EHES.

Gains and Losses

Welcome to MAJ Robert M. CLEARWATER, a recent branch transfer from Ordnance Corps, who currently is assigned to the Air Pollution Engineering Division of U.S. Army Environmental Hygiene Agency, Edgewood Arsenal, MD.

A graduate of Lafayette College, Pa., with a B.S. degree in Civil Engineering, he had also completed the Ordnance Officers Advanced Course. Recent assignments include Secretary of the General Staff, U.S. Army Test and Evaluation Command, Aberdeen Proving Ground and S 3 and 4 for HQ and Maintenance Support Company, 63d Maintenance Battalion, USARPAC.

The Role of EHES in Environmental Quality

The Environmental Health Engineering Service (EHES) of each U.S. Army Medical Laboratory is charged with a mission complimentary to that of the U.S. Army Environmental Hygiene Agency. The EHES supports the Army Preventive Medicine program in each CONUS and overseas major command through field and laboratory investigations and consultation services. It thus provides the commander with an increased environmental engineering capability for the conduct of the preventive medicine program within his command.

The Army Surgeon exercises operational control over the EHES, reviews requests for technical services, programs, surveys, and special studies and staffs reports of findings and recommendations. These services can be classified into five basic categories: Water Pollution, Potable Water, Industrial Hygiene, X-ray Protection, and General Environmental Engineering. With new courses scheduled for EHES personnel in environmental pollution during FY 72, these services will expand into air pollution preliminary studies as well.

Water Pollution Services characterize raw wastewater and determine performance characteristics of wastewater treatment facilities. By determining the water quality of the receiving stream, the adequacy of treatment can be determined to assure compliance with water quality or waste treatment plant effluent standards.

Potable Water Studies provide chemical and bacteriological analysis of raw and treated water from Army installations. The service provides data on the adequacy of water sources and

treatment procedures to insure that drinking water supplies are free of objectionable or hazardous materials.

Industrial Hygiene Surveys determine the presence and extent of health hazards resulting from exposures incident to industrial type operations and provide commanders with pertinent recommendations for elimination or control of hazards found. Areas evaluated include noise exposure; toxic chemical use; exposure to mists, vapor, gases and dusts; and adequacy of illumination and ventilation.

The X-ray Protection Surveys evaluate procedures and controls inherent to performing diagnostic medical and dental radiography. The surveys insure that both technicians and the public are properly protected.

The general sanitary engineering surveys provide broad spectrum environmental engineering studies. In addition, solid waste disposal, mess sanitation, troop and family housing, insect and rodent control, and field sanitation team training support is rendered to supplement installation or MEDDAC programs.

The services of the EHES are available to Army commands, installations, and activities upon request to the appropriate Army Surgeons. The services are designed primarily for Class I installations. Upon request, EHES support may be provided to Class II installations, DOD activities, or other facilities not under the jurisdiction of the Army commander with the concurrence of The Surgeon General and coordination with the U.S. Army Environmental Hygiene Agency.

Pollution Classes Held in Germany

Pollution classes for sewage treatment plant operators and supervisors were recently sponsored by the Army Engineer Command Facilities Directorate and the Army Medical Command, 10th Medical Laboratory, Department of Environmental Engineering. Personnel responsible for 61 secondary sewage treatment plants attended.

The course was part of a continuing service designed to provide sanitary supervisors and plant operators fundamentals on plant operation and pollution control. Included in the course were classes in stream pollution, waste water treatment, plant control, and laboratory exercises. Field exercises were provided at municipal sewage treatment plants. The course demonstrated the desire of American forces to prevent environmental pollution of lakes and streams in the Federal Republic of Germany.

New Videotape on Hearing Conservation

The Environmental Engineering Branch, Preventive Medicine Division, U.S. Army Medical Field Service School (MFSS), Fort Sam Houston, Tex., has produced a new videotape to be used in instructing officer classes at the Medical Field Service School (MFSS).

VT 348, "Hearing Conservation," identifies noise as one of the major occupational hazards in the Army, and shows the most common sources of noise which may induce hearing loss. It outlines responsibilities for the program, describes methods of locating noise-hazardous areas, emphasizes medical and engineering control measures and personal protection devices, and advises where technical consultation and services may be obtained to assist in the program. The videotape is suitable for viewing by all personnel who have an interest in or responsibility for the Army's Hearing Conservation Program.

The script for this 20-minute, color videotape was written by MAJ Paul Silvers, MSC, U.S. Army Environmental Hygiene Agency, in collaboration with MAJ Ferd McEntire, MSC, Environmental Engineering Branch, Preventive Medicine Division, MFSS, who also narrates the program. MAJ William Lamb, MSC, Environmental Engineering Branch, Medical Field Service School, served as technical advisor on the script and on the production of the videotape.

This is the fourth videotape produced by the Environmental Engineering Branch on elements of the Army Occupational Health Program. The others are: VT 203, "Army Occupational Health Program," 12:39 min; VT 232, "Occupational Vision," 15:00 min; and VT 271, "The U.S. Army Environmental Hygiene Agency," 21:24 min. These videotapes are available for professional utilization by military and civilian agencies.

Requests should be addressed to Commanding General, ATTN: MEDEW-TV, Brook Army Medical Center, Fort Sam Houston, Tex. 78234. The information required to be included with the request is listed in the current Brook Army Medical Center Videotape Catalog.

EAR MUFFS: MAJ Ferd W. McEntire, MSC, MFSS, holds ear muffs used to protect personnel from dangerous noise. The videotape also demonstrates a sound level meter used in conducting noise surveys.

Army Nurse Corps

BG Anna Mae Hays, ANC
Chief, Army Nurse Corps

From The Chief

This is an exciting period of internal revitalization for the Army Nurse Corps. This past year has seen the accomplishment of many changes in the Army Nurse Corps and Army nursing and the beginnings of exploration toward other changes. I would like to discuss some of them with you.

As you know, I have desired excellence in all aspects of Army nursing and have devoted most of my energies toward achieving that goal. I have recognized that our planning had to be responsive to today's society and to our rapidly changing nursing world. I was aware that we could no longer afford "tunnel vision" which shed light only on the final objective but that we had to be cognizant of all interacting and intervening forces between our starting point and the final realization of our goal. What interacting and intervening forces?

First, the ever-expanding role of the nurse. Over the past months, I have become increasingly concerned about the delivery of nursing and nursing-related services and the economic and effective utilization of nursing personnel. It seemed apparent that a comprehensive program had to be developed through which the Army Nurse Corps' contribution to the Army Medical Department could be enhanced and its services revitalized. Thus, in February, I directed that a Task Force be convened to address the problems concerned with the practice of nursing in the Army.

The Task Force, nine military nurse consultants, met continuously for 21 days and developed the basis for The Army Nursing-Contemporary Practice Program. The program's objectives are to provide the military community with greater access to personalized, compassionate and comprehensive health care service; relieve specialist physicians of selected functions which qualified nurses can safely perform; and insure career satisfaction conducive to the retention of Army Nurse Corps officers.

The program addresses itself to:

1. The standards of Army nursing practice;

2. The roles, functions, and qualifications of each nurse as he advances from beginning practitioner to master clinician;

3. The required education and planned clinical experiences which the Army Medical Department must provide in military and civilian facilities to further the professional growth of the nurse practitioner;

4. The types of career patterns and personnel policies required to facilitate the program; and

5. The essential support required in order to relieve nursing personnel of their non-nursing functions.

The first draft of the Task Force's report is being revised for final staffing. Resources, funds, and training spaces for the implementation of the program have been requested from the Department of the Army.

We are greatly excited about the proposed program and hope that, once it is under way, it will be the beginning of a more productive and satisfying practice of nursing in the Army—a practice which will better serve the patient, the Army Nurse Corps officer, and the Army Medical Department. We will keep you informed of developments as they occur and will solicit your support and comments throughout the implementation phases.

A second major force has been the marked change in the patterns of education for nursing. Recognizing this, I have submitted proposed revisions to three regulations to the Department of the Army, which, if approved, will have a profound effect upon the composition of our Corps and upon the qualifications required

for active duty as a Regular Army officer or career Reservist. Although not approved as the *Newsletter* goes to press, I have reason to believe they will be in effect very shortly. The proposed changes include the following:

1. Graduates of all programs in nursing acceptable to the Department of Army who qualify for licensure as a registered nurse may apply for an appointment as a Reserve Commissioned officer for assignment to the Army Nurse Corps (AR 601-139); and

2. Prerequisite criteria for appointment in the Regular Army (AR 601-124) for extension of service beyond the obligated tour (AR 135-215) have become more rigid. In each instance, priority for selection for appointment or extension on active duty will be given to the applicant who possesses a baccalaureate degree in nursing. Those who do not hold that degree will be required to demonstrate continued progress toward obtaining it prior to final acceptance for a Regular Army or voluntary indefinite status.

In addition the subsidization of RNSP participants in non-degree-granting programs in anesthesiology for nurses has been terminated (AR 601-135).

I strongly believe these recommended actions will contribute to full use of all nursing manpower toward optimum nursing care and of our contribution to the AMEDD mission. Certainly they will contribute toward excellence in Army nursing. Each has several related goals:

1. To offer the opportunity for all qualified registered nurses to serve in the Army Nurse Corps for an initial tour;

2. To further the goal of a baccalaureate degree as the educational prerequisite for career officers whether in a Regular Army or USAR officer status; and

3. To control the progression in tenure and grade of those Army Nurse Corps officers who do not demonstrate professional growth and desire for continuing education.

Another force has been the inequality of opportunity and benefits for Army Nurse Corps officers. I have strongly advocated changes in legislation or regulations pertaining to minor dependents, maternity leave, and the status of the civilian spouse of the female Army nurse. With recent changes in regulations (AR 601-139, AR 135-120) the personal parity of our male and female Army Nurse Corps officers now approaches that of their military and professional parity.

Irrespective of any force, however, excellence in nursing depends upon you—for you alone hold the destiny of Army nursing in your hands.

What I desire from each of you as you carry out your daily duties is an approach somewhat like that of today's youth, i.e., the probing, forceful questioning of what is; the exploration and determination of what should be; and the strong advocacy and implementation of what can be.

I also ask that you rededicate yourself toward the accomplishment of the mission of the Army Medical Department team. In this time of change, it is essential that our team becomes more of a reality than a cliche. Nowhere are the team concept and team effort more important than in the military-medical profession. The members of the varied Army Medical Department professional disciplines have built a military medical organization that is the world's finest. No one group or professional discipline can accomplish its mission. Only with this understanding will you perform at your highest level of professional competence, and only then will you contribute your greatest potential to the accomplishment of our patient care mission.

To have been Chief of the Army Nurse Corps and its first general officer are honors which I shall forever cherish. They have a very special quality because of each of you. Be grateful and proud that you are fortunate enough to spend some portion of your professional life as an Army nurse. I salute you, extend my deep respect and admiration to you, and wish for you a full, happy, and rewarding life.

COL Blanchfield Dies

I know each of you shares with me a very real sense of loss following the death of our beloved "Little Colonel," COL Florence Blanchfield, USA, Ret., Chief of the Army Nurse Corps during World War II.

As the first woman and the first Army nurse to hold a commission in the Regular Army, Colonel Blanchfield's serial number was N-1. That we today hold full rank and privileges as officers is due in no small measure to her untiring efforts.

Colonel Blanchfield was always an advocate of progress and change, and a continuing source of strength and wise counsel to those who followed her as Chief of the Army Nurse Corps. Each of us is diminished a little by her passing. I have conveyed your deep sympathy and mine to her family.

Attitudes and Patient Satisfaction

LTG Hal B. Jennings, Jr., The Surgeon General, has recently written to each hospital commander, command surgeon, and commander of AMEDD Class II installations expressing his concern regarding the impressions gained by patients from the attitudes of AMEDD personnel. I am certain each of you has read this letter. If not, please do so at once.

I wish to express my strong personal support for General Jennings' recommendations since I share his concern. He referred to gentleness, courtesy, and emphathetic skilled care —these have been the hallmarks of Army nurses through the years.

In today's desired context of the Modern Volunteer Army, it becomes increasingly vital that gentleness and courtesy become a part of all of your nursing. I therefore enjoin all military and civilian nursing personnel to examine his approach to his patients, colleagues, superior, and subordinates. You have an impact upon the total impression of the AMEDD gained by visitors to our activities. Each of you must devote your energies to insure that impression is the one desired by The Surgeon General.

Legislation Supported by DOD

Mrs. Martha Griffiths, Representative from Michigan, introduced a Bill in the House of Representatives (H.R. 2580) which is designed to define the "dependent" spouse of the female member equal to that of the male military member.

Specifically, the husband or unmarried widower would no longer have to be in fact dependent upon the female military member for over one-half of his support before he is authorized benefits that accrue to the civilian spouse of a male member. Several other congressmen and senators also introduced similar bills. I am certain you are all aware that the recent DA Message 182121Z March 1971 authorizes exchange and commissary privileges for civilian husbands of active duty female personnel except for the purchase of uniforms.

Representative Spark M. Matsunaga of Hawaii has introduced legislation to repeal a section of the United States Code relating to reductions in the retirement pay of retired officers of the Regular components who are employed in civilian positions in the U.S. government.

CORPS NOTES

Why Regular Army?

The Regular Army officer of the AMEDD is the well-spring and backbone of successful health care. To be a Regular Army officer means to incur a lasting obligation to cherish and protect one's country and to develop within oneself that capacity and strength to serve his fellow Americans with wisdom, diligence, dignity, and patriotic conviction. I congratulate those of you who have been selected to this status. To those of you who are making or considering a career decision, I strongly urge you to reflect thoughtfully upon a Regular Army conversion.

Do not accept or reject this alternative lightly. Rejection denies to you a great opportunity. Acceptance brings to you a share of a great responsibility. Each regular officer stands in the light of his brother or sister officer, and each shares in the honor and burden of leadership. Dedicated, selfless service to our nation is the primary motivation of the ANC officer in the Regular Army. This adds a second major increment to the proud profession of nursing and makes the military nursing profession a way of life rather than simply an occupation or vocation.

In addition to the pride one may enjoy when being part of an elite group—an ANC officer in the Regular Army—there are some important advantages associated with a commission in the Regular Army.

One of these is the opportunity to remain on active duty for more than 20 years. A Regular Army commission guarantees tenure by law. A reserve commission does not. Most Regular Army officers can now become a major and serve 25 years prior to mandatory retirement. Others can complete 28 years, if promoted to a lieutenant colonel, and 30 years if promoted to a colonel. Reserve officers may serve only as long as the nation's security posture dictates a need for their continued service, normally limited to 20 years of active service including both enlisted and commissioned service.

Although exceptions have been granted during the past decade because of the shortage of nurses, it now appears that all reserve officers will be relieved from active duty at the completion of 20 years of active service. The choice of remaining on active duty beyond 20 years is yours *only* if you are a Regular Army officer.

More importantly from the standpoint of those desiring to further their education, preference is given to the Regular Army officer when applicants are selected for educational programs. This is of particular significance in programs such as the long-term civilian education program and the Army's anesthesiology course for nurses.

Another advantage, often overlooked, is the opportunity of promotion for the RA officer. He is not only considered for a temporary promotion in the Army of the United States but also for a permanent promotion in the Regular Army.

The Reserve officer has and will continue to play a vital role in the Army Nurse Corps. However, as the size of the Army decreases, the significance of a Regular Army commission will in all probability increase proportionately. I seriously urge all qualified Army Nurse Corps officers in the USAR to seek a Regular Army commission and assure themselves of the advantages associated with this status.

Travels of Assistant Chief

COL Louise C. Rosasco represented me at the course, "Current

Trends in Health Care Administration," held at the Medical Field Service School, Fort Sam Houston, Tex., 29 March to 2 April 1971.

She also visited the Medical Field Service School and spent considerable time with the Divisions of Nursing Science, Health Care Research, and Test and Evaluation. COL Marion Kennedy is the Chief, Nursing Service Division, LTC Betty Starkey is assigned to the Health Care Research Division, and LTC Betty Blomer to the Test and Evaluation Division. Colonel Rosasco also had the opportunity to visit the U.S. Army Combat Developments Command Medical Service Agency at Fort Sam Houston and discussed new developments concerned with medical TOE and the planned Field Test of Combat Support Hospital with our nurse representative, COL Margaret Maher.

Because of my recent illness, Colonel Rosasco also attended the National League for Nursing Convention in Dallas 9-12 May. Upon her return, she departed almost immediately for Europe to speak to the ANC officers attending the USAREUR - Seventh Army Medical-Surgical Conference held in Garmisch, Federal Republic of Germany.

ARMY NURSE CORPS CONTRASTS, 1967-71

Strengths:

	April 67	April 71
Total	4604	4729
Fld. Grade	1331 (29%)	1070 (23%)
Co. Grade	3273	3659
Female	3566	3700
Male	1038 (22%)	1029 (22%)

Participation in Procurement Programs:

Degree Granting Programs:	FY 67	FY 71
WRAIN	469	553
ASNP	521	770
RNSP	9	25
	999 (60%)	1348 (79%)
Non-Degree Granting Programs		
ASNP	670	338
RNSP (Anesthesiology	0	30
	670 (40%)	363 (21%)

Educational Preparation:

	April 67	April 71
Doctorate	2	6
Master's	185	229
Baccalaureate	769	1686
	956 (21%)	1921 (41%)

Progress Report, ANC Structure Studies

A preview of the completed raw data collection tools for the ANC Structure Analyses and Program Planning Studies was presented to the senior ANC officers attending The Surgeon General's Conference for Army Chief Nurses in November, 1970.

The study is now listed in the DoD Study Program. The cost benefit alternatives for source data automation of the MEDDAC Nursing Personnel Survey and the Individual Officer Questionnaire were recently reviewed by The Surgeon General who gave approval to let-out the project for interservice contract. LTC Irene Pishak is the designated functional area specialist for the studies and will be assisting the agency selected to complete the studies.

ANC Memorabilia

Several items of historical interest to Army nurses from the old nurses' quarters of Fitzsimons General Hospital have been transferred to the Walter Reed Army Institute of Nursing (WRAIN). These include a lovely portrait of Florence Nightingale and a large photograph of Army nurses stationed at Fitzsimons in 1918. A partial set of monogrammed Army Nurse Corps silver was also transferred and will be used at official ANC and WRAIN functions. In accepting these items, COL Drusilla Poole, Director, WRAIN, stated that the major purpose in collecting such items at Delano Hall is to preserve it as "a place very special to Army nurses."

If there are similar items in your medical activity which are of importance to the Army Nurse Corps and no longer used by ANC officers, I urge you to contact my office immediately.

ANCs As Authors

One of the featured articles in the March issue of the *American Journal of Nursing,* "The Athletic Knee Injury," is written by an ANC officer. The author, CPT Cecil Drain, is now a student in the course in Anesthesiology for Nurses at the William Beaumont General Hospital. April's *Journal* contains an Army Nurse Corps co-author. MAJ Geraldine Felton's "Shift Rotation Is Against Nature" will elicit many a response although the necessity for such a staffing procedure is acknowledged.

MAJ Neil Collins, Course Director, Anesthesiology for ANC Officers, Tripler Army Medical Center, is co-author with COL Robert Moore, Jr., MC, of an article which appeared in the November-December issue of *Anesthesia and Analgesia . . . Current Researches.* The article, "The Effect of a Preanesthetic Interview on the Operative Use of Thiopental Sodium," is of interest to all who care for surgical patients as well as to nurse anesthetists.

We are proud of each author. Their articles should serve as a stimulus for others of you to contribute to our professional journals.

Revison of MOS Descriptions

The revision of the Military Occupational Specialty structure for the Army Nurse Corps has been temporarily delayed pending the final decision concerning proposed changes to the regulations which govern commissioning criteria and the development of the Army Nursing-Contemporary Practice Program. Both actions will influence the practice of nursing and the educational and experience requirements which must be considered in the MOS revision.

PERSONNEL

Changes, ANC Officers, OTSG

LTC Ira P. Gunn has been reassigned from the ANC Branch, Personnel and Training Directorate, OTSG, to the Office of the Nurse Consultant, Consultant Division, Professional Services Directorate, OTSG.

LTC Ramona DELANEY is assigned to

the Assignments Section, ANC Branch, Personnel and Training Directorate, OTSG, to replace MAJ Peter Fiaschi who will attend the Catholic University of America, Washington, D.C., this fall. Colonel Delaney holds a baccalaureate degree from Texas Christian University, and a master of science degree from Wayne State University. She comes to OTSG from the 24th Evacuation Hospital in Vietnam where she was Chief, Nursing Service.

LTC Katherine GALLOWAY has been assigned to the Career Planning Section, ANC Branch, Personnel and Training Directorate, OTSG, to succeed LTC Alma ANDERSON who retires 31 July 1971. Colonel Galloway's last assignment was as Chief, Nursing Service, Institute of Surgical Research, BAMC. She received her baccalaureate degree from the University of Buffalo, and a master's degree in medical and surgical nursing from Western Reserve University. Colonel Galloway holds the coveted "A" prefix to her MOS and is Consultant to The Surgeon General for Medical-Surgical Nursing.

LTC Lyndoll WELLS recently became a member of the staff of the Installations Branch, Plans, Supply and Operations Direcorate, OTSG. Colonel Wells, a former Air Force officer, had been assigned as an Instructor with the Clinical Specialist Course, U.S. Army Hospital and Specialized Treatment Center, Fort Gordon, GA. Her baccalaureate degree was awarded by the University of Wisconsin and her masters in nursing service administration by the University of Minnesota.

Doctoral Degree Conferred

LTC Janet ROGERS was recently awarded the degree Doctor of Education by George Washington University. She is currently assigned at Walter Reed Army Medical Center. The title of her doctoral dissertation is "Impact of Federal Legislation on Occupational Health Programs at Selected Military Installations."

1970 BOVARD AWARD: This year two Army Nurse Corps officers shared the Evangeline G. Bovard Award presented annually to an outstanding officer or officers of the Army Nurse Corps assigned to Letterman General Hospital. This year's recipients were MAJ Oswald Ferry *(left)* and CPT Eileen Gentile. Major Ferry is a nurse anesthetist, currently assigned as Course Director, Anesthesiology for Army Nurses. CPT Gentile is a Clinical Head Nurse of the Recovery Room. Congratulations to each of you!

Officer Undergraduate Degree Program (OUDP)

DA Circular 351-22, "Army Medical Department Officer Undergraduate Degree Civil Schooling Program," 5 Feb 71, announces an education program developed for AMEDD career-oriented officers who do not have a baccalaureate degree. This program permits officers with Regular Army potential or in Regular Army status to earn a baccalaureate degree. This degree is the minimal goal for AMEDD career officers.

Under this program, the ANC officer selected for the AMEDD OUDP will be stationed on a PCS basis at an accredited college or university of his choice while earning a baccalaureate degree in nursing. The officer will receive full pay and allowances and his full tuition support will be provided contingent upon availability of funds. If educational funds are not available at the time of entry into school, the officer may elect to request to participate and pay his own .tuition, fees, and other school connected expenses.

Take advantage of this opportunity and participate in the AMEDD OUDP by submitting your application in accordance with AR 350-219 and cite DA Circular 351-22 as additional authority.

Challenge Examinations— BSN Degree

Many colleges and universities now make it possible for registered nurses to take challenge examinations, used to validate that the challenger possesses the knowledge acquired by others who have taken the course school curriculum.

It results in saved time for the student and prevents duplication of effort. If the student passes the challenge examination, credit for the particular course is established.

Universities individually establish policy pertaining to the kind and number of courses and the number of credits that can be challenged. You must plan carefully if you are attending school on off-duty time to accrue credits to apply for long-term civilian education, or one of the other Army-sponsored educational programs, and intend to take advantage of challenge examinations.

For example, sufficient credit should be accrued before applying for long-term civilian training to allow for an unexpected course which may have to be taken. This is particularly important if you expect to establish credit for several courses through challenge examinations.

Long-Term Civilian Education Selectees

Pursuing a doctoral degree will be: LTC Audrey McLOUGHLIN and MAJs Dorothy BERRY, Beverly GLOR, and Deloros KUCHA.

Twenty-six officers will seek a master's degree: LTCs Patsy ACCARDO and Maurice HENSLEY MAJs Betty ANTILLA, Jerry BENEDICT, Naldean BORG, Betty BRICE, Marietta BUDACK, Peter FIASCHI, Addie JONES, Eileen LINES, Terry MISENER, and James SOKOLOSKI; and CPTs Bruce ALLENBACH, Patricia BASTA, Carolyn BLASDEL, Reuben BLYE, John BRADLEY, Diane CLIFTON, Robert JIMINEZ, Robert McDONNELL, Robert McMAHON, Suzanne SHAFFER, Susie SHERROD, Marita SILVERMAN, Dora STATEN, and Margaret WILSON.

Those entering programs leading to a baccalaureate degree are: MAJs Kathleen CONDON, Dorothea COURTS, Marie FLECHA-AGOSTO, John HARVEY, Aida RIVERA-MORALES, Calude SAMUELS, Betty WHITMIRE, and Mildred WILSON; CPTs Marcus DAUGERTY, Lawrence EBERLIN, John EVANS, Judith FOX, John FRITZ, Jerry HANNA, Sharon LAMBERT, Jackie McENTIRE, Catherine OAKLEY, Edward PESCATORE, Charles ROVINSKI, Byron TAYLOR, Joan WIMETT, William WIMETT, and Sharon ZEINER; and 1LT Walter LANDER.

Key Assignment Changes and Retirements

COL Mercedes FISCHER, Chief Nurse, U.S. Army Pacific, retires 31 July 1971 and will be succeeded by COL Maude SMITH, Chief Nurse, U.S. Army, Vietnam. LTC Barbara LANE will succeed COL Smith. COL Ann BROWNING will become Chief, Nursing Service, DeWitt Army Hospital, Fort Belvoir, VA. LTC Ruth KEGLER will be the successor to Colonel Browning as Chief Nurse, Eighth US Army, Korea. LTC Lois V. JOHNSON will become Chief, Nursing Service, U.S. Army Hospital, Fort Carson, CO.

COL Isabel PAULSON, Chief Nurse, Fourth U.S. Army, Fort Sam Houston, TX, retires 31 July 1971 and will be succeeded by COL Margaret SODT, Nursing Service, Irwin Army Hospital, Fort Riley, KA. LTC Marian J. SETTER will replace Colonel Sodt.

COL Anne ROSE, Chief, Nursing Service, Martin Army Hospital, Fort Benning, GA, retires 31 July 1971 and will be succeeded by LTC Sally STALLARD. LTC Anna E. ANTONICCI has replaced Colonel Stallard as Chief, Nursing Service, Kimbrough Army Hospital, Fort George G. Meade, MD.

LTC Dorothy KLASINSKI, Chief, Nursing Service, U.S. Army Hospital, Fort MacArthur, CA, retires 31 July 1971 and will be succeeded by LTC Wilma CHALMERS.

LTC Janet BACHMEYER, Chief, Nursing Service, Darnall Army Hospital, Fort Hood, TX is being reassigned to USAMEDCOMEUR. LTC Grace LEARNED replaces Colonel Bachmeyer.

LTC Margaret CANFIELD, Chief, Nursing Service, Tuttle Army Hospital, Hunter Army Airfield, GA, has been reassigned to USAMEDCOMEUR. LTC Elizabeth Kumpf has succeeded Colonel Canfield.

Delegation of Authority for Temporary Promotion to Captain in the AUS

DA Circular 624-3, 2 March 1971, continues the delegation of authority for temporary promotion of captain, AUS, to those commanders normally authorized to promote second lieutenants and warrant officers.

It provides for an individual to be promoted to captain, AUS, under the procedures set forth for the lower grades in Section V, AR 624-100 upon completion of a specified period of service. The circular also defines the time-in-grade for promotion eligibility which is gradually lengthened over the first six months of FY 72. Each first lieutenant should review this circular to determine the date of his own eligibility.

ENLISTED NURSING PERSONNEL

The Clinical Specialist

The Clinical Specialist, MOS 91C, is important to the delivery of health care in the AMEDD. He is specifically prepared to use advanced techniques based on established principles in the provision of nursing care to patients in medical facilities around the world. The trained Clinical Specialist augments the professional nursing staff and assists in providing the highest quality of nursing care. Depending upon the situation, he may work under the supervision of the nurse or physician.

Since the Clinical Specialist is such an important member of the AMEDD nursing team, the following statistics give cause for concern:

Authorized Strength (Jan 71)	4910
Actual Strength	3614
Training Requirements (FY 72)	2424
Programmed Training Input	1240
Shortfall	1184

These figures clearly demonstrate the need for more Clinical Specialists. Each of you has a responsibility to assist in improving the situation by familiarizing yourself with the Clinical Specialist Course (DA Pam 350-10) and stimulating interest and encouraging those with potential for advanced training to apply for the course.

I request your whole-hearted cooperation. It is imperative that we succeed in this effort to insure the availability of adequate numbers of AMEDD enlisted personnel required to meet the demands of the AMEDD nursing care mission.

Reclassification of Grade E-8, 91C40

Although the reason for the recent reclassification action of last February was fully explained in the preceding *Newsletter* by the Director of Personnel and Training, I continue to receive queries concerning this action.

The following information is furnished to inform each ANC officer on a matter which affects the welfare and morale of a most important member of the Army nursing team, the senior Clinical Specialist.

The most recent Office of Personnel Operations 45 Report, "Report Consolidation and Projection of Army Strength," reflected that 72 grade E-8, MOS 91C40, are authorized world-wide. There are now 309 individuals who hold a PMOS 91C40 at the E-8 level or are selected for promotion to E-8 in this MOS.

Because of this overstrength, a Reclassification Panel was convened on 16 February 1971 at the Office of Personnel Operations, Department of Army. The purpose of the panel was to reduce this vast overstrength and insure that the best-qualified individuals were selected for each military occupational specialty.

Continuation of this surplus personnel status would severely limit promotions in this MOS from the lower grades and restrict progression of enlisted personnel into the capper MOS 91Z, Medical Senior Sergeant, with a fill of only 80 per cent.

Reclassification of the personnel will be effective on 1 July 1971. Those already selected for promotion will be reclassified on the same effective date and will be promoted in the newly designated MOS with their promotion sequence number unchanged. Individuals reclassified to PMOS 91Z will retain their proficiency pay.

Much effort has been taken to insure that not one 91C40 has lost grade, rank, or pay through this action. In most instances, those reclassified retain the 91C40 as a secondary MOS.

POTPOURRI

Thought for Reflection

Vice Admiral G. M. Davis, Surgeon General, U.S. Navy, has recently stated: "We would do well to heed what patients have taught us for countless years. In an impersonal atmosphere of cold indifference, the simplest procedure can assume the proportions of a monstrous assault. In an attitude of understanding and encouragement, the most formidable situation can be sufficiently molded to allow for patient acceptance."

Abstract for Action

I strongly urge each of you to read and become familiar with the proposals of the report of the National Commission for the Study of Nursing and Nursing Education titled *Abstract for Action.* The Kellogg Foundation has recently awarded the commission a grant of $270,232 to convert the *Abstract* into action.

The implementation phase has three principal objectives: (1) To change patterns of nursing education through the creation of a master planning

committee in each state to oversee nursing education; (2) To cooperate with joint practice committees of the medical and nursing professions to develop congruent roles in health care; and (3) To enlarge the base of financial support for nursing education in order to provide career opportunities that will attract the people needed to assure high-quality nursing care.

Did You Know That:

- Reassignments that require an extension of active duty and/or a request for an inter-theater transfer *cannot* be made based upon remarks contained in the DA Form 483, *Officers Assignment Preference Statement.* Requests for both extensions of active duty and inter-theater transfers must be submitted through channels and approved by the Office of The Surgeon General.
- The Surgeon General desires the appropriate uniform to be worn for official social functions within the AMEDD?
- The *only hospital duty* uniform which may be worn by both military and civilian nursing personnel is the standard issued uniform?
- The first issues of the *American Journal of Nursing* were devoted largely to Army nursing?

Spirit of Nursing Statue Rededicated

The Spirit of Nursing statue, which dominates the nurses' section of Arlington National Cemetery, was rededicated on March 11. The chiefs of the military nurse corps and their deputies participated in the ceremony.

The memorial was originally dedicated in 1938 and honored the Army and Navy Nurse Corps. A new plaque affixed to the statue honors the dead of the three military nurse corps—Army, Navy, and Air Force.

'Tradition in Transition' in Vietnam

Those of you who have recently served in Vietnam may have seen the Vietnamese Nurse Corps Pin with its large superimposed letter "D."

A recent letter from MAJ Allen Perry, USAF, NC, Senior Nurse Advisor, Military Assistance Command Vietnam, explained its significance:

"The letter means 'Dieu-Duong.' The title of nurse along with the concept of nursing is changing in Vietnam . . . to 'Dieu-Duong.' Dieu means to heal and prevent; whereas Duong means to nourish, help, care for, and cherish. Hence the term and concept of 'Dieu-Duong' incorporates the ideals of modern nursing in Vietnam." And modern nursing worldwide, we sincerely trust!

In addition to Major Perry, approximately six Army nurses, all men, are assigned as advisors with the Military Assistance Command Vietnam.

Patent Safety Devices

Those AMEDD activities desiring to procure such items as safety strips and hand grip rails for bathtubs and showers should request these through normal supply channels. Logistics/Supply and Service Division will place the requirement on the Post Engineer who has responsibility for purchase items of equipment.

Uniform News

- The latest word regarding the new white hospital dress for all female nursing personnel is that it will not be fully available in the Army supply system until 1 December 1971. You are therefore authorized to purchase this item of uniform from a commercial firm. Be certain it meets the required military specifications. Remember that only a three-inch hem is authorized.
- Female ANC officers are authorized to wear the new button-closure nurses' cap. It should be available in the Army supply system sometime during the month of December 1971. Individuals who wish to purchase one at their own expense can do so at any authorized commercial uniform outlet. Bobby pins used to secure the cap (white only, please) should be placed so they cannot be noticed.
- In my visits to AMEDD activities around the world, I frequently hear complaints from both male ANC officers and enlisted nursing personnel concerning the buttons on the men's smock. These buttons are frequently broken in the laundry process and thus pose a constant problem of replacement. Action has been initiated to change present military specifications of this smock to require a button which can be removed prior to laundering thus depriving the "button breaking machine" of its function.
- AR 670-5, "Uniform and Insignia, Male Personnel," 1 March 1971, has been published and distributed. This regulation prescribes the authorized material, design, ornamentation, insignia, accessories, manner, and occasion for the wearing of the uniform by male personnel of the U.S. Army. Similar information concerning the hospital duty uniform for men has been submitted as a change to this regulation.

The following is quoted from U.S. Materiel Command, Supply Information Letter Number 2-71, 1 February 1971, concerning the new men's windbreaker jacket:

> Since numerous inquiries have been received by this Center on subject item, the following information is furnished:
>
> 1. DA has approved a new hip-length jacket (Windbreaker) for optional wear by all male personnel of the Army.
>
> 2. The jacket is authorized for optional purchase and wear with the khaki uniform, Army tan uniform and organizational uniforms such as cook's whites and white hospital corpsmen's uniform. It may not be worn in formation. It may be worn with civilian clothing by enlisted personnel, officers and warrant officers when insignia of grade is removed.
>
> 3. Subject item may be obtained through the Post Exchange Service. It is not anticipated this item will be stocked or sold by Army Clothing Sales Stores.

AMEDD Corps' Anniversary Celebration

The Surgeon General's Policy Council recently announced a change in the observation of AMEDD Corps anniversary dates. Beginning in calendar year 1972, there will be an annual Army Medical Department birthday celebration.

Each year one of the six corps will be the primary sponsor of the annual celebration and the corps serving as host will be honored at that

time. The exact date of that occasion will be announced later.

Only special anniversaries of individual corps, such as an anniversary which is a multiple of 25 (25th, 50th, 75th), will be separately celebrated.

Newly Standardized Supplies and Equipment

We are aware that many of you do not have frequent access to federal supply catalogs and supply bulletins. The following recently standardized items are now available for requisitioning through normal supply channels.

Bed lamp, patient (FSN 6230-145-1407): Bedlight has universally adjustable bracket, is suitable for reading, and can be used as an examining lamp. It replaces the old brown bed lamp.

Bulletin Board, Cork: These should be considered as a replacement for old, locally fabricated boards. It comes in two sizes: 36" X 24" (FSN 7195-115-0554) 52" X 40" (FSN 7195-275-1164).

Embossing Machine (FSN 7490-835-0443): This item is similar to the commercially available manual typewriter for making plastic, embossed, self-adhesive labels. Tapes are available in several colors: Black, FSN 7510-995-4893; red, FSN 7510-995-4887; and green, FSN FSN 7510-849-1138. See catalog for other tapes which are available. The machine and tapes must be ordered through U.S. Army Support Center, Richmond, VA. You are strongly encouraged to obtain and use these items for all necessary labeling and no longer use masking or adhesive tape for this purpose.

Men's Pajamas: At long last, the new pajamas, a vast improvement over the older items, are in the system! The coat has V-neck, is collarless and long sleeved, and is of blue check fabric. The trousers utilize snap fasteners instead of strings.

Stock numbers and sizes are:

FSN 6532-111-0698: Coat, man, pajama, cotton, extra small.

FSN 6532-111-0699: Coat, man, pajama, cotton, small.

FSN 6532-111-0700: Coat, man, pajama, cotton, extra large.

FSN 6532-111-0701: Coat, man, pajama, cotton, large.

FSN 6532-111-0702: Coat, man, pajama, cotton, medium.

FSN 6532-111-0703: Trouser, man, cotton, pajama, extra small.

FSN 6532-111-0704: Trouser, man, cotton, pajama, small.

FSN 6532-111-0705: Trouser, man, cotton, pajama, extra large.

FSN 6532-111-0706: Trouser, man, cotton, pajama, large.

FSN 6532-111-0707: Trouser, man, cotton, pajama, medum.

Plastic Medical Card Holder (FSN 7110-030-2845): This item is suitable for wall mounting and is a welcomed replacement for the counter top, locally fabricated medicine card boxes. It allows sorting of cards by the hours at which medications are to be given.

Truck, handbox, with lid (FSN 3519-901-9708): This plastic cart on wheels is a replacement for the older canvas cart used for the transport of linens. Separate carts should be used exclusively for clean or for soiled materials. This cart is easily cleaned and, when used with lid, is a most desirable substitute. The item must be obtained from the Defense General Supply Center, Richmond, VA, through the U.S. Army Support Center, Richmond, VA.

Bowie—Dick Test Indicator (FSN 6530-181-7770)

This newly type classified item, (Indicator, Sterilization, Sensitized Paper, 91 x 12 inches, 31s) is used to test for residual air in prevacuum steam sterilizers and testing should be conducted daily in each prevacuum sterilizer. It is *not recommended* for use in testing for residual air in the gravity displacement steam sterilizer. Procedure to be followed is:

Place a single test pack in the lower front portion of the sterilizer. Pack size should not exceed 12" x 12' x 20. Set sterilizer to normal cycle for sets and packs. Following exposure to steam, open the pack. Examine sheet of concentric circles for color change. The concentric circles turn black when air is absent. Shades of grey and/or uneven color changes indicate the presence of air.

If any discrepancy is noted in the color, request an immediate thorough maintenance check with particular attention given to the operation of the vacuum pump. Retest as above following completion of maintenance work. When a satisfactory test report has been obtained, begin normal daily use of prevacuum sterilizers.

Electronic Temperature Indicators

LTC Catherine Betz, Nursing Methods Officer, Office of The Surgeon General, continues to receive many queries concerning standardization of one or several of electronic temperature indicators. The current state-of-the-art is fluid, the items are expensive, and their use has limitation. Therefore, until a single electronic thermometer can be determined to be entirely satisfactory, the electronic thermometer will not become a standard item. You will be kept informed of any progress toward standardization.

Lillian Dunlap New ANC Chief

As copy for this issue was being readied for publication, word was received that President Nixon had nominated COL Lillian Dunlap for promotion to the temporary grade of brigadier general.

Colonel Dunlap will succeed BG Anna Mae Hays as Chief of the ANC following General Hays' retirement this summer.

The new general is a native of Mission, Tex., and received her R.N. from Santa Rosa Hospital School of Nursing. She holds a bachelor of science degree in nursing from Incarnate Word College, San Antonio, and a master of hospital administration degree from Baylor University.

Colonel Dunlap was assigned to WRAMC following a three-year tour of duty as Chief Nurse, First U.S. Army, Fort Meade, Md. Before that she served for two years as Chief, Army Nurse Corps Assignment Branch, Office of the Surgeon General.

Army Medical Specialist Corps

COL June E. Williams, AMSC
Chief, Army Medical Specialist Corps

DACOWITS

The semi-annual meeting of the Defense Advisory Committee on Women in the Services (DACOWITS) was held in Washington, D.C., and at the Ninth Naval District, Great Lakes, Ill., from 25-30 April. The Army, Navy, Marine Corps and Air Force take turns hosting the meetings and this meeting was hosted by the Navy.

DACOWITS was organized to promote women in the military service and I think it is important you are aware of their activities. The DACOWITS was established in 1956 by the Secretary of Defense and this October will celebrate its 20th anniversary. Limited to a membership of 50, DACOWITS is composed of civilian women who are selected as members on the basis of their outstanding reputations in business, a profession, or public service and their records of civic leadership. Equitable field of interest and geographical representation are also selection factors.

Members are appointed to DACOWITS by the Secretary of Defense for three years. I have an opportunity to nominate women for membership and would welcome suggestions. Members serve as individuals, not as official representatives of any group or organization with which they are affiliated.

The purposes of the committee are:

- To interpret to the public the need for and the role of women in the services and to promote public acceptance of military service as a career field for women.
- To advise the Department of Defense on policies relating to women in the services.
- To recommend measures to insure effective utilization of the capabilities of the women in the services.
- To make appropriate recommendations pertaining to the training, housing, health, recreation and general welfare of the women in the services.

Each DACOWITS member, in her particular field of interest and geographical area, endeavors to increase public acceptance of the concept of military service for women as a facet of good citizenship. The committee carries out a continuing and unified education program about women in the services. It seeks to promote understanding of the principal need for Women in the Armed Forces; to support the mission requirements of the respective Military Services and to fulfill the nation's total manpower requirements in the defense of the United States.

The Directors or Chiefs of Corps of the Women's Military Components participate in the DACOWITS meetings.

There is a Secretariat providing the necessary assistance and services for the conduct of the committee's business. The executive secretary and projects coordinator are women officers of the Army, Navy, Air Force, or Marine Corps. The encumbent executive secretary, an Air Force lieutenant colonel, will be replaced this summer by one from the USMC. Following is a list of DACOWITS members. You are encouraged to contact these ladies and invite them to visit your installations. Only by improved communications with them can they be of maximum benefit to us. They are eager, ready, and willing to meet our women in the service and assist in any way possible.

Appointed in 1969

Mrs. Beverly K. Bain
1363 Pleasant Valley Way
West Orange, NJ 07052
(Occupational Therapist)

Dr. Loretta C. Ford
3040 5th Street
Boulder, CO 80302
(Professor, Public Health Nursing, School of Nursing, University of Colorado)

Mrs. Wilma D. Higginbotham
1831 Oak Ridge Drive
Charleston, WV 25311
(Women's Editor-Charleston Daily Mail)

Miss Katherine S. Horkan
50 Park Avenue
New York NY 10016
Town Center Plaza
1000 6th Street, S.W.
Washington, D.C. 20024
(Co Founder and Executive Vice President of Communications International, Inc.)

Dr. Rachel M. Ice Hubbard
2611 Charing Road, Apt. B
Columbus, Ohio 43221
(Chairman, Food and Nutrition Division, Ohio State University)

Mrs. Helen K. Leslie (1971 chairman)
Box 13221
St. Petersburg, FA 33733
(Executive Vice-President, K&W Supply House, Inc.; Co-owner, Secretary-Treasurer, Krauss Air Conditioning Inc., Krauss Roofing Co., Inc., Stone & Clay Products Corp. and a Civic Leader)

Mrs. Wray B. Lindersmith
4000 Massachusetts Avenue, N.W.
Washington, D.C. 20016
(Director of Sales and Public Relations, Hotel Washington)

Mrs. Myrtle W. Ollison
5101 North Everest Street
Oklahoma City, OK 73111
(Civic Leader)

Mrs. Richard A. Sutter (Betty)
7215 Greenway Drive
St. Louis, MO 63130
(Civic Leader and an Editor of Publications)

Mrs. Donna H. Tibbetts
32 Norway Road
Bangor, Maine 04401
(Registrar, Beal College)

Mrs. E. B. Vogelpohl (Kris Anne)
8 Adler Circle
Galveston, TX 77550
(Civic Leader & Registered Dietitian)

Dr. Norma B. Walker
2413 Alcoa Highway, S.W.
Knoxville, TN 37920
(Pediatrician—Private Practice)

Dr. Mary S. Zink
29 College Heights
Orono, Maine 04473
(Professor, Hussan College and a Consultant, New Horizons Consultants—Private Counseling Agency)

Appointed in 1970

Mrs. William J. Bell (Lee Phillip)
209 East Lake Shore Drive
Chicago, IL 60611
(Television Personality, WBBM-TV)

Mrs. Vivien Davenport
1500 Mims Street, S.W.
Atlanta, GA 30314
(Librarian, Atlanta Public Schools)

Mrs. Marcia Ellingson
3940 East Avenue
Rochester, NY 14618
(Civic Leader)

Mrs. Ellen K. Frautschi
3206 Lake Mendota Drive
Madison WIS 53705
(Research Assistant, University Hospitals, Department of Pediatrics)

Mrs. Marilyn S. Fusfield
42 Riverview Heights
Sioux Falls, SD 57105
(Civic Leader)

Mrs. June N. Gibbs
163 Riverview Avenue
Middletown, RI 02840
(Civic Leader)

Mrs. Virginia B. Kenney
Route 2, Box 104
Barrington, IL 60010
(Civic Leader)

Miss Helen Lundstrom
125 East 2nd, North
Logan, Utah 84321
(Dean of Women, Utah State Univ.)

Mrs. Elly M. Peterson
Route #2
Charlotte, MI 48813
(Civic Leader)

Mrs. Catherine C. Ritchie
35 Hundreds Road
Wellesley Hills, MASS 02181
(Educator and Civic Leader)

Mrs. Estelle M. Stacy
#3 Hilltop Road
Post Office Box 96
Douglas, WO 82633
(President, Stacy Drilling Company)

Mrs. Mary M. Stokes
275 Carolina Avenue, N.E.
Orangeburg, SC 29115
(Civic Leader)

Miss Marie Torre
(Mrs. H. M. Friedman)
57 Rocklynn Place
Pittsburgh, PA 15228
(News Report & Hostess of TV Show "Contact", KDKA-TV)

Miss Antonina P. Uccello
207 Branford Street
Hartforn CT 06112
(Mayor, City of Hartford)

Appointed in 1971

Mrs. Anne Armstrong
Republican National Committee
310 First Street, S.E.
Washington, D.C. 20003
(Co-Chairman, Republican National Committee)

Miss Roberta J. Barnes
70 Barker Circle
Reno, NV 89503
(Dean of Women & Acting Dean of Students, University of Nevada)

Mrs. Mary D. Cain
Chestnut Street
Summit, MI 39666
(Editor/Publisher: *Summit Sun* (Newspaper); *Woman Constitutional*)

Mrs. Margaret Willett Collins
2505 Willow Street
San Diego, CA 92106
(Coordinator of Vocational Education, San Diego Community Colleges)

Miss Grace L. Davis
2057 9th Avenue
San Francisco, CA 94116
(Lecturer, University of California School of Nursing, University of California Medical Center)

Mrs. Elizabeth A. Durick
25 Greening Avenue
South Burlington, VE 05401
(Assistant Vice President for Public Relations & Placement, Champlain College)

Mrs. Eleanor L. Foote
4760 South Inca
Englewood, CO 80110
(Civic Leader)

Mrs. Joyce Gilliam
2000 Frink Street
Gayce, SC 29033
(General Manager, Columbia Wilbert Vault Company)

Miss Anne E. Golseth
2021 South 17th Street, Apt. 214
Grand Forks, ND 58201
(Dean of Women & Assistant Professor of Counseling & Guidance, University of North Dakota)

Mrs. Fran Harris
Special Features Coordinator
The WWJ Stations
622 West Lafayette Boulevard
Detroit, MI 48231

Mrs. Norma J. Herzinger
1037 Sunrise Boulevard
Twin Falls, Idaho 83301
(Women's Editor, *Times-News*)

Mrs. Carol L. Hills
5 Stoney Brae Road
Wollaston, MASS 02170
(Associate Professor of Public Relations, Boston University, School of Public Communication)

Dr. Angelyn A. Konugres
35 Singletree Road
Chestnut Hill, Massachusetts 02167
(Director of Blood Bank; Principal Research Associate in Obstetrics & Gynecology, Harvard Medical School)

Mrs. Sarah McClendon
2829 Connecticut Avenue, N.W., Apt. 604
Washington, D.C. 20008
(News & Radio Correspondent —owner of McClendon News Service)

Dr. Dorothy McMullan
2858 Mariposa Drive
Terre Haute, Indiana 47803
(Dean & Porfessor, School of Nursing, Indiana State University)

Mrs. Betty Milburn
6113 East San Leandro
Tucson, Arizona 85715
(Society Editor & Columnist, *Tucson Daily Citizen*)

Dr. Jean M. Phillips
2141 Owens Road
Oxon Hill, Maryland 20021
(Senior Psychologist, Prince George's County School System)

Mrs. Mary L. Rasmuson
Post Office Box 600
Anchorage, Alaska 99501
(Civic Leader)
Dr. Gladys E. Sorensen
7811 East Lee Street
Tucson, Arizona 85715
(Dean, College of Nursing, University of Arizona)

Mrs. Madera Spencer
2292 Country Club Drive
Montgomery, Alabama 36106
(Women's Editor, *Montgomery Advertiser-Alabama Journal*)

Mrs. Sylvia A. Vinnicombe
13 Roland Mews
Baltimore, Maryland 21210
(Producer/Moderator, WMAR-TV)

Mrs. Gretchen M. Walsh
3447 Hillcrest Road
Dubuque, Iowa 52001
(Psychologist—Dubuque County Board of Education)

Computer-Assisted Hospital Food Service System

Phase Ia of the system, providing support to the Production and Service Branch operation, has been completed and is in the process of final testing. The Extended Recipes, Recipe Delivery Schedule, Food Production Worksheet, Ingredient Summary, Ingredient Breakdown, and Meals Served Record are all in use, with a high level of acceptance on the part of user personnel. Specifications for Phase Ib, nutritional evaluation, are being completed.

Current plans call for implementation of Phase Ia in four hospitals—Fitzsimons General Hospital, Brooke General Hospital, Tripler Army Hospital, and Letterman General Hospital —during FY 1972.

Chief, Occupational Therapist Section

LTC Dorothy Street has been selected to replace LTC Eileen F. O'Brien on 1 October 1971 as Assistant Chief, AMSC, and Chief, Occupational Therapist Section. Colonel Street is exceptionally well-qualified to assume this very important position.

Colonel Street, assigned to the Army Surgeon General's staff in January, will continue to work with the Manpower Group in the Resources Management Office until her new appointment becomes effective 1 October.

She is a Phi Beta Kappa graduate with a degree in sociology from Smith College. Her Certificate in Occupational Thearpy was granted in 1952 from the Boston School of Occupational Therapy, now a part of Tufts University. In addition, she holds two master's degrees—one in psychology from the University of Texas in 1963, and another in hospital administration from Baylor University in 1969.

She has served on the occupational therapy staff at William Beaumont General Hospital, El Paso, Tex.; Walson Army Hospital, Fort Dix, N.J.; Tripler General Hospital in Hawaii, and Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Tex. She was Chief of the Occupational Therapy Section at the 106th General Hospital, Japan, Brooke General Hospital, and Madigan General Hospital, Tacoma, Wash.

What's New?

New Technical Bulletin Army TB 700-1, Navy NAVFACP-268, Air Force AFM 160-15, "Construction and Material Schedule for Military Medical and Dental Facilities," March 1971.

MAJ Timothy Reyburn, Chief, O.T. Section, Irwin Army Hospital, Ft. Riley, reports he has had good results with the "Nerf Ball." This inexpensive foam ball, available at any 5 and 10 cent store, has been used to actively exercise newly repaired hands.

Computer Used in Occupational Therapy

LTC Janet Werner, Chief, Occupational Therapy Section at Walter Reed General Hospital, has begun collecting patient treatment program information to be stored in a computer bank at Walter Reed. The computer bank would serve as a centralized O.T. information storage system accessible by any O.T. in the Army. Every Army O.T. clinic with access to a computer would have a code book to gain access to the computer bank. Request for information of a subject would be answered within an hour.

The computer is only as good as the information fed into it. This project is in the input stage now. You are urged to help by sending information on O.T.-related subjects pertaining to actual treatment. If you have found a particular method of treatment beneficial, attended a course, seminar, lecture or read a good article, send the information to LTC Janet Werner for centralized storage so that it can be shared with your colleagues.

Workshop for Perceptual Motor Dysfunction

Seven Army occupational therapists participated in a workshop for Perceptual Motor Dysfunction at Walson Army Hospital, Fort Dix, N.J., 25-30 April 71.

The course direcor, MAJ Maria Guerrero, and her staff presented a stimulating program which included administration, scoring and interpretation of the test used. The philosophy of treatment and the envolvement of the "team approach were stressed."

The guest speakers, MAJ Barbara Knockerbocker, USA(Ret); Mrs. Danessa Johnson and Mrs. Mary Garrigan enhanced the workshop. All of these guest speakers are former Army OTs.

This course will be conducted again next year. If you are interested in this workshop, you should inform the Chief, O.T. Section, OTSG.

CAKE CUTTING: In April the Army Medical Specialist Corps' anniversary cake at Brooke Army Medical Center was cut by COL June E. Williams, chief of the corps, and BG Edward H. Vogel, Jr., Deputy Commandant of the Army Medical Field Service School.

Visit To Fourth U.S. Army

In April, I visited several installations in the Fourth Army Area and was pleased with the outstanding work of AMSC officers. Installations visited were: Brooke Army Medical Center and HQ, Fourth U.S. Army, William Beaumont General Hospital, Fort Hood, Fort Sill, Fort Polk, and Fort Wolters. Our senior officers, as usual, were performing in a highly commendable manner and I was especially pleased with the performance of our young officers. Approximately 72 per cent of our AMSC officers are serving in the grades of captain, first lieutenant and second lieutenant. With the limited number of senior officers, these young officers are assuming positions of great responsibility in a manner which should bring pride to all of us. Congratulations to you young officers and keep up the good work!

Our corps was honored in San Antonio, Tex., on two auspicious occasions. Upon my arrival at San Antonio International Airport, I was given the Red Carpet Welcome by the San Antonio Chamber of Commerce. A red carpet was rolled out and 15 members of the San Antonio Chamber of Commerce Red Carpet Committee and the majority of our local AMSC officers were lined up to welcome me. Several pictures were taken and the event was shown on local TV stations. The weather was perfect and added to a most enjoyable welcome.

On Thursday, 15 April, we celebrated the 24th Anniversary of the AMSC. BG Edward Vogel, COL Nannie R. Evans, COL Nanette Keegan, and LTC Winifred Louis were in the receiving line with me. There was a large number of guests; the food was delicious, and the nurses at Fourth Army headquarters and Brooke Army Medical Center sent a beautiful floral arrangement. General Vogel assisted me in cutting the beautifully decorated cake. It was one of the nicest AMSC anniversary parties I have ever attended and I want to thank all responsible.

Uniforms

White Cotton Polyester Bengoline Dress

This new hospital duty uniform for female medical personnel is now scheduled for delivery to the Defense Personnel Support Center in November 1971. DPSC has issued a purchase request for 78,000. The center expects the first delivery in November and is attempting to meet an effective date of supply of 1 December 1971. The dress should be available earlier through commercial sources. It may be available for individual purchase in July 1971, depending on how quickly commercial sources are able to produce them.

Smock, Medical Assistants, Man's

Numerous complaints have been received concerning buttons which are lost or broken during the laundry process. A change in the specifications has been requested to require a button which can be removed prior to laundry.

Oversea Service

AR 614-30 contains information concerning assignments, details, and transfers for oversea service. Section III contains a table listing the oversea duty tours for military personnel. By referring to this table, you can determine your tour length in any area of the world.

Medical Activities Report

Each year a Medical Activities Report is sent to The Surgeon General reporting the year's activities at each hospital. There has been a lack of input to the reports from the Occupational Therapy and Physical Therapy Sections. These reports become a part of the historical documentation of the Medical Department. You are urged to discuss this with your chief and become a contributing member.

Dietetic Internship Course

The Course for Directors and Educational Directors of Army Dietetic Internships was conducted at WRAIR, 29 March-1 April 1971. LTC Jeanne P. Sanford, Ph.D, was the course director. Dr. Margaret A. Wilson, Director of the Department of Education of the American Dietetic Association, was the keynote speaker. Her topic was "Education in the Profession of Dietetics—The Future."

HONOR GRADS: *Left:* 1LT Michael C. Kluthe, AMSC, received the Distinguished Honor Graduate Certificate from BG Edward H. Vogel Jr., Deputy Commandant of MFSS. Lieutenant Kluthe was the outstanding student in the AMEDD Officer Basic Course (ANC-AMSC), class no. 6. *Right:* 1LT David M. Clark, AMSC, accepted a similar certificate from MG Kenneth D. Orr, Commanding General of Brooke Army Medical Center and Commanding General of Brooke Army Medical Center and Commandant of the school. He won top honors in class no. 4.

Electric Elbow Evaluated at Fitzsimons

The occupational therapy section at Fitzsimons General Hospital recently participated in the evaluation of an electric elbow unit developed by the Veterans Administration Research and Development Division. The device was fitted on a patient who is a right shoulder disarticulation and a left above-elbow amputee. The electronic elbow unit can flex and extend the elbow independent of the Bowden cable, standard in an above-elbow prosthesis. The training program for the patient followed a pattern of standardized training except for those modifications that were incorporated because of the electronic elbows.

MAJ Louis Carmona attended an orientation course in "Upper Extremity Powered Components" at Northwestern University. The course launched a nationwide field test of a variety of electronic components including an E.M.G.-controlled powered hand. Fourteen VA centers and two military hospitals have been selected to participate in the study.

Courses in AMEDD Facilities

Listed below is the FY 71 schedule of AMSC-sponsored short courses. These courses are described more fully in the FY 72 AMEDD Course Catalog, available in your Military Personnel Office.

Course Title	*Location*	*Dates*
Nutrition Symposium	WRAIR	2 Aug 71- 5 Aug 71
Current Trends in AMSC Management	WRAIR	7 Feb 72-11 Feb 72
Perceptual Motor Dysfunction for OTs	Walson AH	10 Apr 72-14 Apr 72
Educational Technology for AMSC Officers	USAMFSS	17 Apr 72-28 Apr 72
Army Dietetic Internship Faculties	BGH	1 May 72- 5 May 72
Seminar in Anatomy & Physiology	USAMFSS	1 May 72-12 May 72
		15 May 72-26 May 72
OT Educational Supervisors	WRAIR	5 Jun 72- 7 June 72

Selections for Long-Term Civilian Schools

LTC Mary BAGGAN, Kansas State University

MAJ Charles HAMMOND, Emory University

MAJ Sonya LAUBSCHER, University of Denver

MAJ Sally McCANDLESS, University of North Carolina

MAJ Donald SAKSON, University of North Carolina

MAJ Benjamin DAVIS, University of Maryland

MAJ Dorothy MOUNT, to be determined

CPT Martha CRONIN, University of Nebraska

CPT Derrol SATER, University Southern California

Assignments of Key Officers

LTC Eileen B. TREASH: from Director, Dietetic Internship, Letterman GH, to Chief, Food Service Division, US Army Tripler General Hospital.

LTC Beulah Catherine NOBLE: from Dietetic Consultant, USRPAC—Japan, to Walter Reed General Hospital.

LTC Joan GRAZIANO: from USARPAC—Okinawa, to Womack Army Hospital.

LTC Marilyn J. SCHMECHEL: from Brooke General Hospital, to Hq, US Army Medical Command, Vietnam.

MAJ Eleanor B. STRAYER: from Incarnate Word College, San Antonio, TX, to WRAIR, WRAMC, Washington, DC.

MAJ Richard SCHISKA: from USAH, Fort Gordon, to Chief, O.T. Section, Ireland AH, Ft. Knox, KY.

MAJ Ruta KLAVINS: from Walter Reed GH, to Procurement Officer, Third US Army.

Awards

Army Commendation Medal:

LTC Helen CRUICKSHANK, ACM
LTC Priscilla GILCHRIST, MSM
MAJ Bernadine CHOREN
MAJ Mary HUSTON, ACM
MAJ William LOFTON
CPT Linwood THOMES

Retirements

LTC Priscilla GILCHRIST—30 April 1971.

Dietetic Interns

Sixteen dietetic interns completed their internship program in May and June. Congratulations to the following graduates:

Fitzsimons General Hospital:

LT Jay A. CONTRERAS
LT Margaret A. LOCKHART
LT Barbara HAFT
LT Marjorie A. MILLER
LT Janet E. ZIMMERMAN
LT Elizabeth CUMMINGS
LT Brenda K. MACKE
LT Jon LARSON
LT Mary NOWAK
LT Sarah PARKER
LT Eva L. QUINONES
LT Karen P. VAIRA

Walter Reed General Hospital:

LT Gregory McCALL
LT Patricia WHITE
LT Ruth KERSCHNER
LT Diane D. NEVILLE

Occupational Therapy Clinical Affiliates Graduate

The Occupational Therapy Section added 11 new qualified therapists to their rolls. Our best wishes go with these therapists as they go forth to pursue their chosen profession.

Brooke General Hospital Graduates include:

LT Linda FOREMAN
LT Merri MEREDITH
LT Fred RITZEMA

Walter Reed General Hospital:

LT Dolly BROWNFIELD
LT John GRAHAM
LT David LIVINGSTON
LT William PAGE
LT Andrew PAGE
LT Andrew SHAW
LT Donna TREVARTHAN
LT Dixie UNDERWOOD
LT Ted BECKER

Executive Office

COL William C. Luehrs, MSC, Executive Officer

OTSG Article Review Ended

In keeping with The Surgeon General's policy to decentralize many AMEDD functions that can be carried out by local commanders, General Jennings recently revised a major, long-standing policy affecting the preparation of scientific and professional articles.

Until recently, any speech to be presented to a civilian audience or article written for publication in a civilian journal by a member of the Army Medical Department had to be submitted to the Office of The Surgeon General for review and clearance. Worldwide Message 301802Z, Mar 71, Subject: "Change in AR 360-5," has revised this requirement as follows:

"Effective with receipt of this msg, Section III, paragraph 8c(3) of AR 360-5 is revised as follows:

"(3) Scientific and professional articles, speeches and presentations prepared by members of the U.S. Army Medical Department will be cleared at the lowest command level. Cases of doubt shall be resolved in favor of submission.

"(a) In cases of doubt, manuscripts will be forwarded in triplicate, with two copies of all illustrations, through channels, to The Surgeon General, ATTN: MEDTL-R, Department of the Army, Washington, D.C. 20314.

"(b) Submissions forwarded from the Office of The Surgeon General to SAOPI-FOI for DOD final clearance must be unclassified.

"(c) To assist The Surgeon General in establishing a scientific file of medical and related health information, commanders will forward to The Surgeon General, ATTN: MEDTL-R, Department of the Army, Washington, D.C. 20314, one copy of each manuscript intended for publication or presentation that has been cleared locally."

This revision in policy will be published as Change 1 to AR 360-5 shortly.

However, commanders of Class II activities who are scheduled to present a talk to a civilian audience at a conference or meeting of national importance, or who have prepared an article for publication in a national journal, will submit an original and two copies of their manuscript to The Surgeon General, ATTN: MEDTL, for review and clearance. This measure is necessary since no commander should be placed in the position of having to clear his own manuscript.

Resources Management Office

BG Louis J. Hackett, MC, Special Ass't for Resources Management

Operating Budget

The latest revision of the Program 8 Medical budget for FY 1971 is shown on the right. An additional $34 million was expected before year-end to meet CHAMPUS and medical equipment requirements.

Command operating budgets for FY 1972 have been received and are being reviewed by the DA staff. Congressional hearings were scheduled in April and May. Apportionment hearings with OSD and the Office of Management and Budget were conducted in June. During these reviews and hearings. the Resources Management Office defended the requirements which will lead to adequate funding for all commands in FY 1972 for essential medical care. All commands should be prepared to furnish additional details to support their COB requirements.

The Program Objectives Memorandum (POM) was submitted to HQ DA in April. This represents the initial FY 1973 budget. Revisions of this will be made in the months ahead as force level changes occur. Requirements for several new programs were included, such as for training physician assistants, nurse clinicians, sanitary engineers and biomedical technicians; for clinical research in Army hospitals; for plastic lenses; for computer automations; for pollution control; for reduction of dependence on drugs; and for occupational health.

DIRECT OBLIGATIONAL AUTHORITY AS OF 30 APRIL 1971

CONARC	$116,466,900
USAREUR	25,498,000
USARPAC	21,873,000
USARSO	895,000
USARAL	862,400
TSG	252,187,400
USMA	1,421,000
OTAG	1,420,000
USAREC	7,985,000
TOTAL	$428,985,000

Exemption from Personnel Ceilings

On 15 April 1971 a DA letter outlined a new policy of eliminating civilian personnel ceilings on a trial basis for FY 1972. Available funds will be controlling. However, in order to prevent excessive hiring in relation to workload or unusual reduction in force, thresholds will be established above and below the personnel strength supported in the budget. These thresholds will be included in the manpower vouchers. Commands will be requested to explain major deviations which occur in manpower usage and cost without accompanying changes in productivity. Prior to the end of the one-year trial, commands will be requested to provide a narrative evaluation of their manpower operations without prescribed ceilings to DA headquarters.

Command and Program Evaluation by Army Comptroller

Following a schedule of Army command reviews, the Comptroller of the Army surveyed Class II medical activities from November 1970 to February 1971. Objectives were to improve the programming and budgeting process and to economize the use of resources. Major areas of analysis were funding levels, personnel resources, organizational structure and potential duplication in performance of missions and functions. Upon completion of the survey, the Vice Chief of Staff was briefed on the findings as were also The Surgeon General and key staff officers. Class II medical facility commanders and the OTSG staff are reviewing the recommendations, which are generally considered helpful and represent an objective evaluation of medical management.

Seminar on Ambulatory Services

The increasing importance of outpatient services has prompted The Surgeon General to hold a seminar at Brooke Army Medical Center next summer. MG Kenneth Orr, MC, commanding BAMC, will be the director. The objectives of this conference will be to evaluate the methods developed by the Army Medical Department for handling large numbers of outpatients; to consider appointment and scheduling systems; to find ways to make use of technological advances; and to consider how to use health care personnel more effectively. Of course, the general goal is to improve service to patients and make better use of available resources. General Orr will develop the agenda and plans for the seminar.

Price Trends in AMEDD Supplies

A comprehensive study has been undertaken to determine the impact of inflation and technological advancement on medical and non-medical supplies (items with a unit cost of under $200) used in medical facilities. The impact on standard versus non-standard items will be considered. The knowledge of actual trends supports budget justifications and in turn provides the resources required to procure supplies. Currently, actual costs

have in most cases exceeded projected costs—indicating a need for detailed study in this area to determine the cause.

The study will consider all standard medical items in the DOD merical supply concerns, data on non-medical items from the respective NICP's and possibly data from selected hospitals.

The study's first phase is to obtain and analyze data on standard and non-standard medical items from the Defense Personnel Support Center (DPSC) at Philadelphia, Pa. The selected management approach has been chosen as the basis for study of the 11,623 medical standard items. It has been determined that approximately 15 per cent of the total standard medical line items comprise over 80 per cent of the total dollar value of demand. These items are known as "best seller" items, and have been selected as the basis for study. A random sample (10 to 20 per cent) of the best seller list will be selected for detailed review and analysis.

Phase I of the study will also include detailed examination of data obtained from five or six of the major drug and medical supply concerns on non-standard medical items.

Phase I results will show the impact that inflation and technological advances have on medical standard and non-standard items.

Phase II will include a similar analysis on non-medical standard and non-standard items and possibly visits to selected hospitals to obtain additional data for final analysis.

The final report will include a detailed analysis of the overall impact that inflation and technological advancement have on both medical and non-medical items of supplies. The results of this report will provide the basis for adjustments to future budgets for anticipated supply costs.

Current Trends in AMEDD

• The number of dependents per active duty Army member is increasing. The current reduction in the size of the Army is being accomplished by reducing the number of draftees who are primarily single personnel. Therefore, the relative proportion of married personnel in the Army has increased. This also has increased the average number of dependents per individual soldier. In FY 1969, the ratio of dependents per soldier was 1.14, in FY 1970 it rose to 1.23, and in FY 1971 there will be an estimated 1.34 dependents per soldier, increasing to 1.44 in FY 1972. This ratio is important in forecasting dependent medical workloads.

• Dispensary and clinic visits have continued to increase in all commands over the past 18 months. In FY 1969, with an average active duty Army strength of 1,503,100, there were 66,000 daily dispensary and clinic visits. In FY 1970, the average strength dropped five per cent but daily visits are projected to remain at the FY 1969 average of 66,000.

• The CHAMPUS workload has been increasing each year since FY 1965. Although, there was a five per cent decrease in the average strength of the active Army from FY 1969 to FY 1970, the average daily beds occupied by dependents of active duty Army personnel in civilian hospitals rose from 1,977 to 2,144.

Of all active duty Army dependents who were hospitalized in FY 1969, 46 per cent used the CHAMPUS Program and in FY 1970, 47 per cent used the program. The CHAMPUS Program for FY 1971 is expected to level out at 2,054 average beds occupied each day by active duty Army dependents, or 47.5 per cent of the total hospitalized in military and civilian facilities during this year.

Retired Army personnel and dependents of retired and deceased personnel are also increasing their use of CHAMPUS each year. This trend is not expected to level out within the next few years because of anticipated population increases among these groups. For example: the average number of beds occupied each day by retired Army personnel in civilian hospitals was 146 in FY 1968; 205 in FY 1969; 251 in FY 1970; and an estimated average of 302 and 356 respectively for FY 1971 and 1972. Increased publicity and wider knowledge of the CHAMPUS Program are factors causing greater use.

Directorate of Plans, Supply & Operations

COL Harold G. Stacy, MC, Acting Director

New Generation of Military Hospitals

On 15 April 1971, the Assistant Secretary of Defense, Health and Environment, announced that Travis Air Force Base, Calif., has been selected as the site for the prototype hospital of the study on the "New Generation" of military hospitals. The Naval Training Center, Orlando, Fla., was selected as an alternate site should Travis Air Force Base become ineligible at a later date.

This Phase II of the study is concerned with the design and construction of a prototype military hospital that will use the advanced management concepts, sub-systems and components identified in Phase I of the project. LTC William C. Jones, MSC, Installation Branch, Plans Division,

Directorate of Plans, Supply and Operations, has been designated as the OTSG Project Officer for this phase.

Army Surpasses Half Million Mark in Blood

The United States Army has now provided more than one-half million units of blood to Southeast Asia. This figure was reached last April.

The Army commanders, surgeons and their respective staffs can be proud of their accomplishments. The principal Army installations participating in the blood program are as follows:

1st Army	*3rd Army*
Ft Devens	Ft Benning
Ft Dix	Ft Bragg
Ft Knox	Ft Campbell
Ft Lee	Ft Gordon
	Ft Jackson
5th Army	*6th Army*
Ft Leonard Wood	Ft Ord
Ft Hood	Ft Lewis
Ft Polk	
Ft Sam Houston	
Ft Sill	

Revised AR 40-425 Published

During April 1971 a revised version of AR 40-425, "Outpatient Treatment Records," was distributed throughout the Army. This revised regulation, effective 1 May 1971, now allows the hand-carry of outpatient records between medical facilities by the individual to whom they pertain, or the parent or legal guardian in the case of minor children.

Although not specifically stated in the regulation, x-rays (when required), pertaining to the outpatient records, may also be entrusted to the patient for delivery to the next medical facility or physician. However, each case should be determined individually since the record contains the Radiographic Reports (SF 519a) that pertains to the x-rays.

All medical facilities should take action to give the hand carry procedures outlined in AR 40-425 the widest possible local publicity. These procedures will greatly reduce the records transmittal workload as well as relieve the necessity for maintaining files no longer active due to the departure of the individuals to whom the records pertain.

Registrar Listing

By the time this *Newsletter* reaches you, a registrar locator listing will have been mailed to all individuals with a primary or secondary 2431 MOS. This listing will be updated and distributed semi-annually. The list's accuracy will depend largely on the corrections submitted by the individuals appearing on the printout.

If you think you should be on the listing, but have not received your copy, write to Office of The Surgeon General, Department of the Army, ATTN: MEDDD-OA, Washington, D.C. 20314, for a copy. Corrections to the listing should also be forwarded to this address.

TDRL Cases—Processing Guidelines

The new U.S. Army Physical Disability Agency (APRC) revised administrative guidelines for the processing of Temporary Disability Retired List (TDRL) cases. The following are extracts from these guidelines:

- When an agency review of the case of a member on the TDRL indicates that further action by medical authorities is required before completion of review, the APRC will return the entire case file to The Adjutant General (TAG), ATTN: TDRL Section. The transmittal letter will provide details of the action or needed information. The APRC will furnish an information copy of the letter to the Physical Evaluation Board (PEB) concerned.
- If a case file received by a PEB is found to be inadequately documented and the deficiency can be corrected without further medical examination of the member, the PEB will contact the hospital, TAG or other appropriate agencies, and make an effort to obtain the needed documentation or correct the deficiency. Should this effort be nonproductive, the procedures below will be followed.
- If a case file received by a PEB cannot be adjudicated because of deficiencies that cannot be corrected without further medical examination of the member, or that require other documentation, the PEB will return the entire file to TAG, ATTN: TDRL Section. The letter of transmittal will provide details of the additional information or documentation needed to permit adjudication of the case.
- TAG, in turn, will either obtain the required documentation or forward these cases to the appropriate hospital requesting the desired action be accomplished. If the case does not require further action by the hospital, TAG will return the file to the appropriate PEB. If the required action involves the hospital, the request to the hospital will specify further that the case will be forwarded by the hospital to the servicing PEB upon completion of the necessary action unless other disposition of the case is indicated.
- The PEB, upon receipt of the case file and completed action, will process the case.

JCAH Standards

The Joint Commission on Accreditation of Hospitals has confirmed that 1 July 1971 will be the effective date for the revised standards for hospital accreditation. Single copies of the new *Accreditation Manual for Hospitals,* which received final approval of the JSAH Board of Commissioners in December, are being sent by the Joint Commission to all registered hospitals in the United States and to all accredited hospitals overseas.

Additional copies of the manual are available from the Joint Commission at $8 for a loose-leaf binder edition and $2.25 for a soft-cover edition. (The soft-cover edition is priced at $2 apiece when purchased in quantities of six or more.) Copies can be ordered from the Joint Commission on Accreditation of Hospitals, 645 No. Michigan Ave., Chicago., Ill. 60611.

Periodic TDRL Examinations

During the second week of last April, the number of names on the Tempo-

rary Disability Retired List (TDRL) passed the 16,000 mark. This is the largest the TDRL has ever been and the number has become alarming when one considers that five years ago the list contained less than 4,000 names. One significant factor in this growth is, of course, the increase in the size of the Army combined with the action in Southeast Asia.

However, the peak in casualties placed on the TDRL because of 1968-69 combat actions has passed but the TDRL has not reflected the subsequent reduction in casualties. Another factor has been the tendency to retain some members on the TDRL until their next re-examination in "12 to 18 months" when, in fact, immediate removal is reasonable and proper. Many of these members have thus remained on the TDRL for five years.

Special efforts have been made to identify and promptly remove from the TDRL those members whose conditions have stabilized or so improved that they are now fit. Members having less than 20 years of service—who have improved so that their disabilities are ratable at less than 30 per cent—are also subject by law to removal and separation with severance pay even if their disabilities are not stabilized.

Physical examinations of individuals on the TDRL should be performed to provide the Physical Evaluation Board (PEB) with complete information to determine physical fitness and disability percentage. Stereotyped sentences or verbatim transcriptions from previous medical board proceedings do not adequately describe a member's current condition.

Examining physicians should remember that percentage rate of disability ordinarily is decided in terms of loss of function, especially in cases involving orthopedic, neurological, and psychiatric conditions.

Color photographs are helpful and should be taken whenever indicated to illustrate disfiguring scars and lesions of the face, scalp, and neck; muscle injuries with loss of muscle mass; range of motion of the fingers; and other selected cases. When in doubt as to the requirement, include photographs. Careful measurements of range or motion using the methods described in TM 8-640/AFP 160-14 and Appendix IV, AR 40-501, are important to a fair appraisal of a member's functional impairment. These are only examples to illustrate the need for detail documentation since PEBs seldom see the disabled member and the Army Physical Review Council and Army Physical Disability Appeal Board never do.

Physical Evaluation Boards and the Army Physical Review Council have been requested to carefully evaluate each TDRL report of reexamination to help remove members as promptly as applicable law and Army policy will permit. However, the success of this effort depends to a large degree on the quality of medical examinations and resulting medical board reports.

Radiological Emergency Medical Teams

AR 40-13 prescribes the mission and functions of Radiological Emergency Medical Teams (REMT) available for world-wide use in emergency situations where persons are/may be subjected to significant internal or external exposures of ionizing radiation.

The AR requires Walter Reed Army Medical Center, Brooke Army Medical Center, and Letterman General Hospital to establish a REMT consisting of technically trained and equipped AMEDD personnel. They must be qualified to evaluate potential health hazards from ionizing radiation resulting from a nuclear emergency, and advise on the management of nuclear casualties. Each team has a secondary mission of assisting in providing emergency medical care.

Radiological emergency medical teams are required *only* at those locations specified above. They should not be confused with the emergency medical teams at CONUS installations required by CONUS Army plans to provide *emergency medical treatment* in support of the military assistance effort to civil authority.

Request for Conversion of Bed Space

Paragraph 37c, AR 40-418, concerns authority for changing normal and expanded bed capacities of hospitals. The regulation requires hospital commanders to obtain prior authority from The Surgeon General for any and all proposed alterations, additions or modifications in their respective facilities that will change current and mobilization bed capacities. This also includes reassignment of permanent bed space for other uses (AR 40-2).

AMEDD CONUS Base Mobilization Expansion Plan

Realistic AMEDD mobilization planning is of utmost concern in these times of increasing international tensions. It must be accomplished without any decrease in the quality of performance of essential day-to-day operations, so that a rapid and efficient response can be made to any emergency situation up to and including full mobilization.

The new Army Medical Department CONUS Base Mobilization Expansion Plan (AMEDD-CBMEP) has been distributed by Department of the Army Letter, dated 20 May 1971. The Plan contains detailed medical mobilization planning guidance to all commands and agencies subordinate to Headquarters, Department of the Army, to develop supporting mobilization expansion plans. Major changes in the new Plan include the following:

- The classification of the Plan is "CONFIDENTIAL" (the superseded Plan was classified "SECRET"). This will increase the use, distribution, and accessibility of the AMEDD-CBMEP, and all supporting mobilization expansion plans.
- Distribution instructions will permit the AMEDD-CBMEP to be forwarded down to the installation level.
- Based on a recent reevaluation of the need for CONUS ambulance

trains, it was concluded that there is no requirement for these trains in either a mobilization situation or in a domestic emergency. Accordingly, references to ambulance trains no longer appear in the AMEDD-CBMEP.

• With regard to the submission of the "Availability Listings of Forces—Civil Defense Report" required by Annex J of the AMEDD-CBMEP, for the preparing agencies convenience, an appendix to this annex has been added listing the categories to be used for designating capabilities of available forces.

• In accordance with current DA continuity of operations planning, the Plan indicates the emergency relocation of OTSG elements to more than one emergency relocation site.

• All information concerning Emergency Operations Plans, including testing, is now contained in the basic portion of the AMEDD-CBMEP (see pages 8 and 9). This information was formerly divided between the superseded Plan and Chapter 5 of the AMEDD Program Document.

• In Annex B (Explanation of Terms), there is a further elaboration on the type of space that can be counted in computing expanded bed capacity. Countable additional space includes space on porches and in solaria *when inclosed and considered as a permanent part of hospital buildings provided such space is not realized by elimination of day rooms.*

• Because patient-holding facilities at CONUS aerial ports of debarkation are provided by the Air Force, the practice of designating specific CONUS Army hospitals to provide debarkation beds has been discontinued. All CONUS Army hospitals will, however, continue to accommodate patients evacuated from oversea areas to CONUS in accordance with the medical regulating procedures prescribed in AR 40-350.

• During mobilization, it is planned to use Veterans Administration hospitals for hospitalizing Army patients requiring prolonged care and *expected to return to duty.* To accomplish this, The Surgeon General will obtain approval from the Secretary of the Army and coordinate requirements with the Chief Medical Director of the Veterans Administration.

• Appropriate portions of the AMEDD-CBMEP have been revised to reflect the new realignment of geographical boundaries of CONUS Armies, and the consolidation of the Fourth and Fifth U.S. Armies.

• The U.S. Army Hospital, Sandia Base, Albuquerque, N. Mex., is now included as a Class II AMEDD activity of The Surgeon General. Other changes in the distribution include the addition of the U.S. Army Medical Optical and Maintenance Agency, Denver, Colo., and the elimination of the U.S. Army Regional Dental Activity, St. Louis, Mo.

• TDA hospital centers, included in the current Army Reserve force structure, have been reintroduced in the AMEDD-CBMEP. These centers will serve as command and control elements for certain Class II AMEDD hospitals to include non-industrial facilities (motels and hotels) to be converted to hospitals.

• Appendix 2 of Annex G, "AMEDD Reserve Components TDA Units Having CONUS Mobilization Base Missions," has been annotated "To Be Published." This appendix will eventually indicate the home station, mobilization installation and assignment for each of these units. It will be published in a subsequent change to the AMEDD-CBMEP when stationing data becomes available.

• A major change has been made in the allocation of bed requirements to CONUS Army medical treatment facilities. This change is based on a realistic appraisal of surveys conducted under a DA Hospital Facilities Survey Program. An important objective is to conduct similar surveys of these facilities every three years or whenever a complete revision of the AMEDD-CBMEP is contemplated.

Air Ambulance Unit Activations

Air ambulance units are scheduled for activation in CONUS as Vietnam phases down. Locations and priorities will be based on military density (active and retired) of an area and the need for geographical aeromedical coverage. Units *cannot* be activated for the Military Assistance to Safety and Traffic (MAST) program since it is predicated on a service being performed within training limitations and without interference in the unit's primary mission.

Recent activations include the 151st Medical Detachment (HA) at Fort Bragg, N.C.; the 78th Medical Detachment (HA) at Fort Carson, Colo.; and the 32d Medical Detachment (HA) at Fort Ord, Calif. Platoons of the 507th Medical Company (Air Amb) are scheduled for movement to Fort Hood, Tex., and Fort Sill, Okla. in the near future.

Navigation/Automatic Stabilization Equipment

MAJ James J. Truscott, MSC, has been reassigned to the Aviation Branch, OTSG, enroute to the Command and General Staff College. He will act as project officer to coordinate the requirements for an air ambulance navigation system and provide input to the U.S. Army Combat Developments Command, Medical Service Agency for a Materiel Need proposal.

Use of AMEDD Aviation Resources

Current reductions in funds and resources demand maximum use of air ambulance assets. Training should take first priority to insure the highest quality in aviators and crew members. However, commanders are urged to use their air ambulances, whenever feasible, as a management tool.

Frequently these flights can be combined with training flights to provide dual utilization. Aircraft flight hours are reviewed each month by the Director of Army Aviation, Office, Assistant Chief of Staff for Force Development. Unit moves, aircraft replacement and aircraft withdrawals

are predicated on productive utilization.

Major Changes Programmed for Optical Program

Plans are under way for the greatest change in the optical fabrication program since its inauguration as an Army function and responsibility—first in 1917-1918 in World War I and again, in 1942, during World War II.

The Surgeon General in coordination with the Navy and Air Force medical services, has decided to issue impact-resistant lenses in all spectacles fabricated by Army optical laboratories as soon as supplies and equipment are available during the first half of fiscal year 1972.

In fiscal year 1972, clear hard resin (plastic) ophthalmic lenses will be issued to about 15 per cent of prescriptions with the remainder being furnished with heat-tempered glass lenses.

The change to issue of impact resistant lenses has resulted from a series of tests and studies. Several tests of plastic lenses were conducted in CONUS, Alaska and Panama under field and garrison conditions. The test conclusions indicated that plastic lenses provided greater comfort to spectacle wearers because of lessened weight and greater clarity, but the lenses were subject to marring and scratching.

Plastic lens provide an impact resistance to small and large missiles greater than opthalmic glass. A major deficiency is the limited capacity of industry to produce plastic lenses. It was found that the total plastic lens production in the United States was less than 25 per cent of military services requirements.

With the ultimate objective of furnishing plastic lenses to all spectacle wearers, the plastic lens program will be phased over a five-year period. This phasing is based on industry's capacity, the state of the art, and the need to keep replacement requirements to a minimum.

Because of scratching and marring, plastic lens will be issued first to those personnel who must wear corrective eyewear constantly and who will provide greater care for their glasses. The completion of the transition to plastic lenses is programmed for fiscal year 1976. It is believed that military services requirements will cause, first, an expansion in industrial capacity; second, improvements in plastic material, or the development of a coating material to provide a surface hardness approximating glass, and third, a means for tinting plastic lens that will provide uniform color and light transmission.

After the decision on plastic lenses, the Food and Drug Administration published a series of proposals in the Federal Register that impact-resistant lenses only will be sold in the United States after 31 December 1971. To fulfill this objective, The Surgeon General in coordination with the Navy and Air Force determined that all spectacles fabricated subsequent to 31 December 1971 will have heat-treated lenses except for those authorized plastic lenses.

A target date of 1 October has been set for optical laboratories world-wide to begin heat treating of lenses; however, the actual date will depend upon delivery of essential equipment to fulfill workload requirements. Heat testing units will be established in battery format in each laboratory to perform this task and to test the effectiveness of the heat treating process on each lens. In future years, as the ratio of plastic lenses increases, there will be a corresponding decrease in lenses subject to the heat treating process.

A summary of the types of spectacles to be furnished with plastic and those with heat treated lenses will be published as Change 25 to AR 40-3, and provides the following:

• Cellulose Acetate Frame Spectacles (standard gray frame)

—Personnel requiring a single-vision correction of plus or minus 3.00 diopters or greater in the spherical portion of the lens when written in minus cylinder form will be furnished with clear plastic lenses.

—Personnel with corrections of less than the power indicated above and those requiring multi-focal lenses will be furnished with crown glass heat-treated lenses.

—Tinted lens prescriptions (all colors and light transmission) will be furnished with crown glass heat treated lenses.

• Aviation spectacles (sunglasses and magnesium fluoride-coated glasses) will be furnished with crown glass heat-treated lenses.

• Spectacle inserts for protective masks will be furnished with crown glass heat-treated lenses.

• Personnel employed in industrial occupations or subject to eye-hazardous conditions will be provided with heat-treated glass industrial safety thickness lenses, a minimum of 3mm thickness, when prescribed by the examiner.

Another important change in fiscal year 1972 is the introduction of a newly standardized black frame during the second half of the year. The heavier black frame, more modern in design, should prove to be a highly acceptable item. In a recent Army-wide personnel survey, 68 per cent of enlisted personnel indicated a preference for a black frame.

The measures described above will continue optical fabrication as a viable program. With more than 35 per cent of military personnel wearing spectacles, the program is geared to provide optimum service to spectacle wearers. The AMEDD operates 12 laboratories; six in CONUS and six in overseas commands. A production high of nearly 1.7 million pairs of spectacles was reached in fiscal year 1970, an anticipated 1.5 million will be fabricated this fiscal year, and more than 1.2 million pairs are forecast for FY 1972 as military services strengths are curtailed.

Statistical data on the percentage of Army personnel wearing spectacles by category and age groups was published in Volume 1, Number 3 (Oc-

tober 1970) of the AMEDD *Newsletter*.

First Aid Dressing

The current standard field dressing for use by the individual soldier and medical corpsmen is FSN 6510-935-7084, "Dressing, First Aid, Field, Individual Troop, Camouflaged, 100mm by 120mm." This dressing has two pads, one fixed and one movable, intended for the bandaging of a through-and-through wound with one dressing. Experience in Vietnam, substantiated by tests at the U.S. Army Medical Department Test and Evaluation Activity, Brooke Army Medical Center, Fort Sam Houston, Tex., has demonstrated the deficiencies of the two-pad dressing, particularly the:

- Difficulties in adjusting the movable pad without compromising sterility.
- Difficulties in opening and fluffing out both pads, which requires excessive handling.
- Difficulties in detaching and unrolling the bandage affixed to the pads.
- Lack of dressing pliability which compromises ease of application.

The professional consultants to The Surgeon Generals of the Army, Navy, and Air Force met with representatives of the procuring activity (the Defense Personnel Support Center), and representatives of the manufacturer to consider the problems of the current dressing and evaluate a new dressing that is based on the design of the original Carlisle one pad dressing. The consultants recommended a return to the one-pad dressing.

The proposed new one-pad dressing, because of manufacturing improvements, will permit the individual soldier to carry two bandages in his first aid pouch. Where there is a need to bandage a through-and-through wound, or multiple wounds, two or more single-pad dressings may be used.

Hearing Aid Accessories and Repairs

Medical supply officers play an important role in support of active duty and retired military personnel who use hearing aids. After an individual has been issued a hearing aid, the local medical supply officer becomes the point of contact at the Army medical facility for replacement and repair of defective hearing aids.

When a defective hearing aid is brought in for repair, the medical supply officer should check the batteries, receiver cord, and the electrical and mechanical contacts. Defective batteries and receiver cord should be replaced and the contacts cleaned. If the hearing aid still fails to operate, the complete hearing aid, less batteries, will be shipped by the medical supply officer by registered mail to the Army Audiology and Speech Center, WRAMC, Washington, D.C. 20012, together with DA Form 2407 (Maintenance Request). The name, grade, service number, and SSN of the hearing aid user will be entered in section 16 of the form, with a description of the defect or complaint. A copy of DA Form 2407 will be furnished to the user as a receipt for the hearing aid. Either the repaired or a new instrument will be returned by the Center to the medical supply officer for return to the user.

Detailed instructions on requisitioning of replacement batteries, parts and accessories is contained in Section XI, AR 40-3.

Every effort should be made by medical supply officers to insure that defective hearing aids are processed and repaired with minimum of inconvenience to the user.

Training of Maintenance Personnel

Manufacturers of technical medical equipment have been cooperating with the AMEDD in establishing courses for supplemental training of qualified AMEDD equipment maintenance personnel. These special courses are aimed at training AMEDD personnel in the maintenance and usage concepts of late models and newly developed diagnostic and therapeutic devices and equipment.

Commanders should program funds for this type of training, as expenditures for this training will most likely be offset by savings in contract maintenance costs which would have been expended because of a lack of in-house technical skills.

The AMEDD National Maintenance Point maintains contact with civilian manufacturers relative to training opportunities. Whenever possible short course training programs are scheduled at manufacturer facilities. These courses enable the training to be concentrated on military medical applications. With the great variety of models and makes of biomedical equipment, medical commanders should also make direct contact with manufacturers for additional training on specialized equipment when, in their opinion, such action is warranted.

The rapid expansion of medical technological developments within the health care program requires that medical equipment maintenance skills must be continually updated. All commanders are urged to use available civilian training courses to assure that the medical equipment maintenance program has the capability for repair of all types of medical technical equipment.

Irregular Procurement Actions

Inquiries received by The Surgeon General indicate that AMEDD personnel have, either with or without knowledge of procurement statutory restrictions, obligated the Government for procurement of goods of services without proper authority.

AR 600-50, "Standards of Conduct for Department of the Army Personnel," prohibits Army personnel, other than contracting officers and their duly authorized representatives, from obligating government resources for payment of goods and services.

Unauthorized procurement actions may incur potential financial liability for the individual and also may embarrass the Department of the Army in its dealings with firms unfamiliar with procurement laws and regulations.

Protests Against Award of Contracts

Protests on contracting officers' actions reviewed by OTSG indicate the need for prompt and decisive action in resolving questions raised by industry on decisions of a contracting officer.

The number of protests historically rises during the fourth quarter of each fiscal year when it is desired to complete procurement actions by year-end. This increase reflects haste, inadequate preparation of solicitations, and the hurried offers submitted by industry.

Contracting officers must assure that solicitations are clear and concise and that all required clauses and provisions are included. Protests should be processed and resolved at the lowest level possible; however, the head of the procuring activity should be advised promptly of protests in accordance with OTSG Regulation 715-1.

If questions arise about the responsiveness of an offer or whether the offeror should be determined nonresponsible, guidance should be requested from OTSG, ATTN: MEDDD-LM. When there is an urgent requirement for supplies or services, preliminary guidance may be obtained from the Chief, Procurement Section, AUTOVON 8-22-35535.

A contracting officer's decision that an offer is nonresponsive or a bidder nonresponsible requires careful evaluation and sound, prudent judgment. When a decision has been made, bidders should be advised in decisive terms as promptly as possible.

Contracting officers are reminded that an easily readable and understandable solicitation may prevent an extended delay in making an award, or loss of funds because a valid contract cannot be executed.

Stock Funds Support the Supply System

The Army Stock Fund is a working-capital or revolving fund established primarily to finance procurement, stockage for inventory, and sales (issues) of standard, common-use, recurring demand type items of supply. All standard medical items are procured with stock funds. Inventory items are sold to customers (medical facilities etc.) of the fund.

The revolving fund aspect is achieved by requiring customers to pay for material drawn from inventory, and the collected funds are used to replenish the inventory of items that were sold. The divisions of the Army Stock Fund are classified as wholesale operations or retail operations.

Within the Army, the wholesale division operates under the U.S. Army Materiel Command. Subdivisions (Subhome Offices) of the U.S. Army Materiel Command Division (USAMCD), ASF, are located at each Army National Inventory Control Point and Army Class Management Activity. The Defense Supply Agency and the General Services Administration also operate wholesale divisions for their commodities. Retail activities requisition the required materiel from the wholesale divisions citing funds that will reimburse the wholesale division.

The Surgeon General operates the medical materiel division of the AMC wholesale stock fund. This "Subhome Office" supports the purchase of components for the MUST hospital modules, supports inventories of Prepositioned War Reserve Stocks (PWRS), finances Foreign Military Sales (FMS) and Grant Air purchases under the Military Assistance Program, and finances the purchases under the Medical Equipment Program (MEP).

PWRS assets on hand and on order are valued at $63.7 million, and sales under the programs related above are estimated at $19.4 million for FY 1971. The Surgeon General is responsible for budget presentations for wholesale and retail divisions to the Departments of Army and Defense.

The retail divisions of the Army Stock Fund are located at command levels, i.e., CONARC, Army Materiel Command, and the four major overseas commands. The retail divisions provide the supply support for facilities and units within prescribed territorial or command limits.

For administrative purposes, the Department of Army included The Surgeon General, Army Strategic Communications Command, and Army Security Agency in the Army Materiel Command, Installations Division (USAMCID), in the retail division. The retail elements finance the supply pipeline i.e., the inventories maintained at each location to support the facility. When, for example, a medical clinic requires some antibiotics, it submits a requisition to the medical supply officer who issues the items and secures reimbursement from appropriated funds.

As commander of the AMEDD class II system, The Surgeon General operates a subhome office of the retail division, which finances medical materiel inventories at all class II medical activities. The retail division also finances stocks of other commodities at the AMEDD Class II Installations, i.e., Walter Reed Army Medical Center, Fitzsimons General Hospital and Valley Forge General Hospital. Inventories in the AMEDD Class II retail division are valued at $12.8 million, and FY 1971 sales are estimated to be $45.8 million.

The Surgeon General, in his responsibilities for medical materiel, receives monthly stock fund reports, stock fund budgets, and Financial Inventory Accounting reports from all major command channel stock fund divisions. The Surgeon General is responsible for information on worldwide medical inventories; furnishing budgetary requirements to the Defense Personnel Support Center; and is Program Director for Program 8M funds (formerly BP 2400) who assists the Deputy Chief of Staff for Logistics/ Department of Army in review of stock fund budgets and related compatability to appropriated funds.

Evacuation of Patients to WRGH

Walter Reed General Hospital has been experiencing difficulties in the

receipt of patients being evacuated in from other hospitals. All facilities which evacuate to WRGH should take action to assure that they are not guilty of the following deficiencies:

a. Failure to send copies of transfer orders with patient.

b. Failure to indicate fund cites in transfer orders.

c. Failure to indicate in transfer orders that return to home station upon completion of hospitalization is authorized. This is of particular importance regarding patients evacuated from outside CONUS.

d. Failure of evacuating hospital to brief non-medical attendants of the extremely limited on-post housing available at WRGH, the advisability of bringing a modicum of personal effects in a hand bag due to the non-access to personal luggage during flights, the high cost of living in off-post facilities in the Washington, D.C. area, and the fact that return of non-medical attendants through the Air Evacuation system must be in conjunction with the return transfer of the patient.

While these are problems experienced by WRGH, each one represents an area of basic evacuation procedure which, if violated, detracts from the accomplishment of the basic AMEDD mission. All facilities should examine their exacuation procedures to assure that a smooth, efficient, and responsive internal system is in effect.

Professional Services

BG Thomas J. Whelan, Jr., MC

Administrative Aspect of Trauma

When formulating a plan of total patient care for the soldier who has received mutilating or permanently disabling injuries, due consideration should be given to the effect that an expeditious retirement or delayed disposition will have on the man.

In reviewing a number of charts on such patients, it was found that in several instances the man whose disposition was delayed suffered a significant irretrievable economic loss. For most soldiers of the lower enlisted grades who had sustained severely disabling injuries, an expeditious retirement will serve in some degree to lessen the socio-economic impact of injury on the soldier and his family and thus is in his best interests.

The accomplishment of this expeditious retirement rests both with the physician and with the medical administrative services. Specifically then, how soon after injury is it proper to start Medical Board actions and exactly how important is this action to the patient? For the purposes of illustration, I will consider patients in the lower enlisted grades who sustained bilateral lower extremity amputations, patients who by no stretch of the imagination will return to active duty.

First, how to decide when to start the administrative action? The guidelines for disposition are quite clearly spelled out in AR40-3. Excerpts from three portions of this regulation follow: First, section II, para 4-h:

> Prolonged definitive medical care is not provided for U.S. military patients who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis taking into consideration the interests of the government as well as those of the patient. Such patients will neither be retained nor separated, however, *solely* for the purpose of increasing their retirement or separation benefits.

Section II—para 4-m:

> Army personnel in this category (on active duty for over 30 days) who are *not likely* to recover sufficiently to be medically fit for return to active duty within 12-15 months will be processed for disposition upon attaining optimum hospital benefits.

What exactly are optimum hospital benefits? This point is clarified in AR40-3, section I—para 2 n—"Optimum hospital improvement for disposition purposes":

> That point during hospitalization when after "essential initial" medical treatment the patient's medical fitness for further active service can be determined and it is considered probable that further treatment for a reasonable period will not result in any material change in the patient's condition, which would alter his type of disposition or amount of separation benefits.

By these guidelines, we find that in a bilateral amputee we can determine his unfitness for further duty on the day of injury and since he is already 100 per cent disabled, nothing can change his separation benefits. Thus the patient may well have obtained optimal hospital improvement for disposition purposes the day the patient arrived from Vietnam. Please note, there is no requirement that we must terminate medical care once a Medical Board is finished. The accomplishment of this administrative action should in no way alter the course of medical treatment. It is simply another aspect of total patient care.

How important is this action to the patient? Let us consider some actual cases where I think this question will answer itself.

Case Number 1

C. G. PFC USMC
Injury: Bilateral above knee amputation
Active duty pay $180/mo
V.A. Compensation $638/mo
Differential $458/mo

Date of Injury	29 Jun 1970
Admitted CONUS Hosp.	14 Jul 1970
MEB to Registrar	2 Nov 1970
Date retired	9 Feb 1971
Total CONUS Hospitalization	6¾ months

Distribution of Time	*Appropriate Monetary Differential*
Admission to completion of MEB (Medical Time) = 3½ mos	$1603
MEB Completion to retirement (Administrative Time) = 3¼ mos	$1489
Total Differential	$3092 for 6¾ months

Case Number 2

J. B. PFC USA
Injury: Bilateral above knee amputation and an above elbow amputation on the left.
Active duty pay $180/mo
VA Compensation $705/mo
Differential $525

Date of injury	4 Jul 1970
Admitted CONUS Hosp	21 Jul 1970
MEB to Registrar	17 Sep 1970
Date Retired	8 Dec 1970
Total CONUS Hospitalization	4½ months.

Distribution of Time	*Approximate Monetary Differential*
(Medical Time) 1¾ mos	$ 919
(Administrative Time) 2¾ mos	$1394
Total active duty/ VA differential	$2313 for 4½ mos hospitalization

The next table demonstrates 10 additional cases showing the monetary differential between active duty pay and VA compensation for the period of hospitalization. Please note that the approximate average dollar loss per man was $5,500.

Name	*Rank*	*Months Hosp*	*AD Pay*	*VA Comp*	*Total Diff*
J.C.	E-3	18	$180	$700	$9,360
D.A.	E-3	10	180	616	4,360
M.N.	E-3	16	180	616	6,976
J.L.	E-4	12	249	560	3,732
D.C.	E-4	11	249	616	4,037
J.K.	E-4	18	312	729	7,806
R.H.	E-4	13	249	588	4,407
J.G.	E-4	12	249	560	3,732
W.F.	E-3	19	180	500	6,080
G.E.	E-4	12	249	560	3,732

Average loss $5,500 per man

Thus a delay in disposition can make considerable difference to the patient and I believe this is worthy of some consideration.

In summary, then, I believe it is in the best interests of the patient and the government in most cases to provide expeditious retirement when we as physicians can see that the nature of the trauma will result in significant permanent disability precluding the return of the patient to duty. It is necessary that both the medical and administrative personnel work together to achieve this goal. To this end I would make three suggestions.

1. That we try to make operational through the cooperation of the appropriate medical departments of the Armed Forces and the Veteran's Administration an instant retirement by which obvious cases of 100 per cent total permanent disability could be medically retired and begin receiving VA benefits with an absolute minimum of administrative delay.
2. That physicians be made cognizant that an expeditious retirement can, at times, have a significant meaning to the patient and consider this factor in planning the over all course to follow.
3. That the medical social worker be actively involved as part of the treatment team. By his evaluation of the socio-economic impact of the injury, he can assist the physician in making timely administrative decisions.

Finally, let me emphasize that there should be no reasons for proper administrative actions to interfere with continued optimal medical care. When appropriate, the patient may be retained in the military hospital on retired status and still receive his Veteran's Administration benefits.

Lateral Transfer of Specialized Medical Equipment

With the development of sophisticated expensive equipment and with the ever-recurring problem of transfer of specialists, it becomes important that provisions of AR 40-61 para 5-5, page 5-3 be used when applicable.

This directive should constantly be considered by the specialist when he has acquired a piece of equipment that might not be used after his transfer to his new duty station.

Reach to Recovery

This Foundation, under the sponsorship of the American Cancer Society, is a voluntary, non-profit, educational organization whose sole purpose is to provide a rehabilitation program for women who have had radical breast surgery. The program is designed to meet their psychological, physical and cosmetic needs. The foundation was originated by Mrs. Terse Lasser in 1953 with funds made available by her late husband, J. K. Lasser.

From personal experience, the volunteers in this organization have been a tremendous help to patient and surgeon. All surgeons performing radical breast surgery are well-aware of the patient's post-operative problems. At the surgeon's invitation, these volunteers will visit the patient in the hospital demonstrating exercises, offering suggestions for her comfort and an explanation of various prosthesis, suggesting clothing adjustments and where to get bathing suits and many other important supporting points.

These volunteers can and will help our post-mastectomy patients if we ask them. If you do not know how to contact a volunteer, reach your local division of the American Cancer Society or write to: Reach to Recovery 1814 Broadway, New York, N.Y. 10023.

Pediatric Levels of Immunity Declining

The 1970 United States Immunization Survey, conducted by the Bureau of the Census in cooperation with the Center for Disease Control, noted declining levels of immunization against diptheria-pertussis-tetanus (DPT), polio, and measles in children 1-4. It is obvious that the general public and the medical community has become increasingly complacent toward the risks of these diseases.

Hazards of declining immunity are real, not theoretical, as indicated by the recent outbreaks of diptheria in several areas of the U.S. In at least one of these areas is a major concentration of military and dependents. Several cases of diptheria have been reported in military dependents. Outbreaks have generally been associated with low levels of population immunity. Diptheria vaccine in the form of pediatric DPT, or of the adult (TO) preparation has been shown to be

highly effective in prevention of disease.

Polio immunization levels have declined steadily in the United States population since 1964, and levels in some areas have declined sufficiently to lay them open to the threat of epidemic polio. Unless and until polio is eradicated worldwide, and this goal is not yet feasible, it must be considered an active threat. A recent case of nonparalytic polio in an unimmunized military dependent serves to emphasize the importance of early immunization.

Measles immunization levels, increasing since the licensed vaccine was introduced in 1963, sharply declined in 1970. At the same time measles incidence rose to the highest levels since the national measles eradication campaign began in 1966. The Morbidity and Mortality Weekly Report of CDC for the week ending 24 April 1971 recorded the highest measles incidence in the past five seasons.

It is likely that the advances made in prevention of these diseases will be further reversed unless vigorous efforts are made to insure that the pediatric population particularly receives timely and complete immunization.

The Army Medical Department seeks to provide the highest quality of preventive and therapeutic medical care to the active/retired military member and to his dependents. To this end, care must be exercised to insure that the military dependent population maintains high levels of immunity. Current recommendations are outlined in TB MED 114, Immunizations, dated 25 May 1970.

New Vaccines Licensed

The Department of Health, Education and Welfare recently announced licensing of combined measles-rubella and combined measles-rubella-mumps vaccines.

The combined vaccines make possible immunization of children against more than one disease with a single injection. This should improve public acceptance of measles and rubella immunization, an important consideration during this time of national concern over these two diseases.

Where local resources permit, consideration should be given to inclusion of these combined agents in the routine pediatric immunization program.

Malaria Among Vietnam Returnees

At the time of the expansion of military activities in Southeast Asia, malaria was predicted to be a significant health problem and that prediction has proved true.

The related problem of malaria occurring in personnel after their return from SEA has exceeded the expected magnitude. Expectations were based on the assumption that there would be complete or nearly complete compliance with the chloroquine-primaquine chemoprophylactic program including the continuation of the weekly tablet for the eight-week period after departure.

In 1965 when the troop buildup began there were less than 100 cases reported among returnees. In 1970 over 2000 cases occurred among returnees not being separated immediately upon return. This increase corresponds to the increase in total number of returnees, but the ratio of cases to total returnees has more than doubled over the 1965-70 period. About 80-85 per cent of the malaria occurring among returnees is vivax malaria.

Vivax malaria is more easily treated than falciparum, and is not known to have developed resistance to chloroquine-primaquine prophylaxis. The increasing incidence among returnees of the type of malaria most responsive to the prophylaxis program, leads to the conclusion that compliance with the program is inadequate and not improving.

This presents a serious health problem not only for those returnees who become ill but for others as well. In many areas of the U.S. mosquitoes capable of transmitting malaria are common. More than once outbreaks in CONUS of malaria transmitted by such mosquitoes have been traced to infected military personnel returned from malarious areas. Several recent outbreaks reported among drug users who share injection equipment have also been traced to Vietnam returnees.

Unfortunately there is no easy answer to this problem of malaria among returnees. Full compliance with the prescribed chloroquine-primaquine prophylaxis program would eliminate the great majority of cases but all efforts to date to improve compliance have not been successful.

Various alternate plans are being considered which might be more effective. At present, however, we ask all AMEDD personnel to consider themselves as health educators and to urge compliance with the prophylaxis program by everyone with whom they have contact. Of particular importance would be increased command emphasis at the unit level.

Meningococcal Vaccine

The first meningococcal disease season in which the group C meningococcal polysaccharide vaccine has been used extensively is ending as this is written.

The experience to date is encouraging. In past seasons this vaccine, developed at the Walter Reed Army Institute of Research, has undergone extensive field testing with very promising results. This season, beginning 1 July 1970, the decision was made to use the vaccine as an operational measure to terminate outbreaks of group C meningococcal disease.

In addition, two posts were selected to be the sites for a controlled study to test the hypothesis that prolonged group C vaccine use would result in the emergence of disease caused by meningococci of other serogroups. These studies began in early January at Fort Knox and Fort Ord and were terminated in May.

At neither installation was there appearance of disease caused by other serogroups. At four other basic training installations the vaccine has been used to terminate disease outbreaks. In each instance it has been effective with

the result that the total number of cases occurring this season will be significantly lower than during the 69-70 season, this in spite of the fact that cases occurred during the July to December period at a rate in excess of that of the previous year.

Thus it appears that the meningococcal group C polysaccharide vaccine has proven to be an effective addition to the available preventive measures against the group C disease which is most common among recruits at this time.

AR 40-562, "Immunization Requirements and Procedures"

Revision of AR 40-562 has been completed and it has been sent to the printers. Publication is anticipated about the time this article appears so distribution should be made soon if not already under way. Our purpose here is to list the more important changes from the previous edition.

- Smallpox reimmunization interval
- Typhoid basic series in Area I is reduced to a single orienting dose except for alert troops and personnel on orders to overseas areas. The reimmunization interval overseas is unchanged at three years, while in Area I no reimmunization is required except for alert forces. Only the acetone killed dried typhoid vaccine is now authorized and the typhoid-paratyphoid vaccine is deleted.
- All reference to typhus immunization is deleted.
- Yellow fever immunization is required only for travel to endemic areas or from endemic areas to receptive areas. Areas IIY and IIYC are established to define endemic areas and include Central and South America and Africa south of the Sahara.
- Area IIC, where cholera immunization is required, is expanded to include Korea and Africa. In addition, the former U.S. Public Health Service requirement for proof of cholera immunization of travelers returning from cholera areas to the United States is deleted.
- Plague immunization is required only for travel to Area IICP and the number of boosters required in a normal 12-month tour in Area IICP is established as one if a dose of vaccine was given within one month prior to arrival in the area. The jet injector may be used to administer the first dose of plague vaccine but syringe and needle must be used for all subsequent doses.
- Both live oral adenovirus vaccine and meningococcal polysaccharide vaccine may be given to recruits at the direction of The Surgeon General.
- The basic series of trivalent oral vaccine is increased to three doses at eight week intervals with no reimmunization required.
- The requirement for measles immunization of children traveling overseas is changed to a recommendation.
- The interval between administration of live virus vaccines is increased to 30 days to minimize interference. Concurrent administration of these vaccines is authorized in certain circumstances.
- A standard address is established for use on the PHS Form 731 (International Certificate of Vaccination) for all military personnel.

There are other minor changes throughout the regulation but those listed above are the most important and will have the greatest impact. It should be remembered that this regulation should be used with TB MED 114, "Immunizations," which provides more specific technical guidance for the entire immunization program.

Veneral Disease

The United States is in the midst of an epidemic of venereal disease.

Reported cases of infectious syphilis increased 8 per cent in FY 1970, reversing the annual decline in cases since 1965. The U.S. Public Health Service estimates there are ½ million Americans with undiagnosed syphilis. Reported cases of gonorrhea increased 16 per cent during FY 1970; an estimated two million cases were treated during the year, making gonorrhea the most common reportable communicable disease in the country.

A phenomenon of the current pandemic of venereal disease as noted worldwide is a silent reservoir of infection in females. In the U.S. it is estimated that as many as 1 in 20 sexually-active 20-24-year-old females may be infected with gonorrhea.

As a result of the increasing concern about the threat posed by venereal disease, the National Commission on Venereal Disease was recently established. Its first meeting was held in Washington, D.C., in April. The commission, under the auspices of DHEW, is composed of representatives of 14 national medical organizations, USPHS and DOD. COL Jerome H. Greenberg, Chief, Preventive Medicine Division represents the Army Medical Department.

The commission is specifically charged with outlining ways to improve the medical profession's knowledge of venereal disease, and its clinical and preventive medical management; with devising ways to increase cooperation between practitioners of medical and public health authorities; with indentifying areas of VD research; and finally with recommending implementation of a program to reduce the national impact of VD.

Hospital Carpets

The Surgeon General recently recommended that use of carpets in medical facilities be restricted to administrative prestige areas only and that carpets not be used in patient care areas.

Current information concerning carpet use in medical facilities is inconclusive. The positive aspects for appearance, noise control, and morale are recognized. Problems of sanitation, fire hazard, static electricity, and cost have not been satisfactorily resolved. DOD is currently evaluating carpet use at two military hospitals; results of this study are expected in approximately one year.

'Batronic Ventilaide' Device Unsafe

The Food and Drug Administration, Department of Health, Education and Welfare recently announced that the "Batronic Ventilaide" and its predecessor, the "Batronic Resuscitator" are totally worthless for pulmonary ventilation, respiration, or resuscitation.

The devices are produced by Batrow Laboratories, Inc., Branford, Conn. Because use of these devices in an emergency situation could have tragic results, the widest dissemination of information concerning this item is desired.

Adenovirus Vaccines

Acute respiratory disease (ARD) is the major cause of lost time among basic trainees so much research has been done to determine the causes of ARD and how to prevent it.

Many different etiologic agents have been implicated but the two most important agents causing ARD admissions are adenoviruses types 4 and 7. Extensive efforts of the Walter Reed Army Institute of Research have produced safe and effective vaccines against these two agents.

The vaccines are live attenuated viruses given orally in tablet form. During the 1970-71 respiratory disease season both vaccines were used routinely at all basic training installations with striking results.

Admission rates at all eight BCT posts are significantly reduced below expected levels based on the experiences of prior seasons. The reductions in weekly admission rates among basic trainees has been 75 per cent or more at most installations during March when rates are normally maximal. The amount of savings in time and money from this reduction in disease is tremendous.

However, the possibility of the emergence of other agents producing significant disease is a very real one. With this thought in mind work is continuing to develop equally effective vaccines against those agents felt to be most likely to replace adenovirus types 4 and 7 as the most important causes of ARD in basic trainees.

DDT—2,4,5-T Decisions by EPA

On 15 January 1971 the Environmental Protection Agency (EPA) announced that the remaining Federal registrations for the use of DDT were cancelled. (Note: A notice of cancellation means only that the use of a pesticide is being reviewed, not banned).

An intensive 60-day review beginning 18 January was conducted to determine whether or not DDT uses and certain uses of the herbicide 2,4,5-T should be suspended as an imminent hazard to the public. The effect of a suspension order would be to immediately halt all interstate shipment of affected pesticide products.

On 18 March 1971 the EPA decision on the registration of DDT and 2,4,5-T was announced. In the statement underlying the registration decisions made by EPA concerning products containing the pesticides DDT and 2,4,5-T (as reported in the *Environmental Reporter,* 26 May 1971, Vol 1, No. 48) the agency said that although drafting detailed criteria is a "practical impossibility," several general considerations will be "weighed in determining the need for initial or continued registrations of particular economic poison." The considerations included:

The nature and magnitude to the foreseeable hazards associated with use of a particular product. Such hazards may apply directly to human health, domestic plants and animals, wildlife, or to the environment generally. Also relevant is whether the hazard is inherent in the normal use of the product, or whether it results solely from misuse.

Concurrently, the nature of the benefit conferred by use of a given product must be weighed. Pesticides are used for a variety of purposes, some more important to the public health and well-being than others. Some pesticides help control important disease vectors, others aid in production of food supplies. The nature of the benefit must be weighed. The magnitude of the social cost of foregoing use of a given economic poison must be considered. Alternatives to use a given poison and any problems associated with such a substitution must be considered.

In summary, each question of initial registration, cancellation, or suspension or an existing registration must be individually addressed.

DDT. The statement concluded that after "applying the foregoing analysis and the criteria of risk and benefit to the products containing DDT, this agency has determined that no suspension of such products is warranted pending completion of the administrative process of cancellation which has been commenced".

2,4,5-T. Regarding 2,4,5-T the statement said that after careful consideration of petitioner allegations and of all other relevant factors, "the administrator has determined that . . . the uses of 2,4,5-T which have not been suspended posed no imminent threat to the public, and should be permitted to continue during the pendency of the administrative proceedings now in progress."

Uses for DDT

The Department of Defense policy on the curtailment use of DDT is uneffected by this decision at this time. DDT will only be used for the following purposes:

- Application to interior surfaces of dwellings in oversea areas for malaria control.
- Use of tracking patches for mouse control in locations where abundant food and water exists.
- For bat control in roosting areas.
- For control of stored product insects in warehouses by application to walls and floors only.
- For protection of wool and other animal fiber materials.
- Use of micronized DDT in aircraft as directed by quarantine agencies.
- Use of DDT, pyrethrum aerosol for treatment of aircraft as directed by quarantine agencies.
- For emergency control of black-

flies during military operations in oversea areas only.

With the above facts in mind, the insect control recommendation in FM 21-10, Field Hygiene and Sanitation, July 1970 and TM 5-632, "Military Entomology Operational Handbook," 1965, should be revised to exclude all uses of DDT except those covered by the DOD policy.

Videotapes for Training Programs

The Preventive Medicine Division, Medical Field Service School (MFSS), Brooke Army Medical Center, has produced a number of videotapes for use in their instruction. These tapes are available to qualified military organizations for use in their training programs.

The tapes are available only in one inch helical scan Ampex format and two inch Quadraplex Broadcast Standard.

Request for these tapes should be addressed to:

Commanding General
Attention: MEDEW-TV
Brooke Army Medical Center
Fort Sam Houston, Texas 78234
Telephone—Autovon—471-6107/5123
Commercial 221-6107/5123

A current list of the available tapes follows:

36 Basic Principles of Arthropod Surveys, Parts 1, 2 & 3
37 Bacteriological Analysis
38 Medical Statistics
56 Mounting Insects, Parts 1 & 2
57 The Medical Comparator—Modified OTA and pH Techniques
179 Preventive Medicine Problems/SEA
180 Tropical Diseases of Military Importance
186 East Africa, An Area Study
203 U.S. Army Occupational Health Program
205 Biology and Control of Rodents
223 Industrial Hygiene Operations
230 Viral Hepatitis: Etiology, Diagnosis and Treatment
231 Viral Hepatitis: Epidemiology, Prevention, and Control
232 Occupational Vision
234 An Area Study of South Korea
259 UAR-Egypt: An Area Study
266 Meningococcal Meningitis: The Disease and its Control
271 U.S. Army Environmental Hygiene Agency
273 Venomous Animals: Snakes
274 Venomous Animals: Arthropods

Existed Prior to Service Condition (EPTS)

There has been a significant number of individuals erroneously discharged from military service within four months of entry because of an EPTS medically unfitting condition. This is due to improper application of the appropriate medical fitness standards.

Medical boards must be familiar with paragraph 5-9, AR 635-200 and Chapter 2, AR 40-501, and applicable appendicies before making a recommendation for separation action. Examples of conditions causing erroneous separations that have been received in the Office of The Surgeon General are:

Hearing: An individual can be totally deaf in one ear if the hearing in the good ear is within normal limits. Reference paragraph 2277 and appendix II, AR 40-501.

Eyes and Vision: Improperly evaluating the amount of refractive error in spherical equivalent. Reference paragraph 2-13c, AR 40-501.

Inguinal Hernia: This condition is considered as LOD unless it is a matter of record on the individuals SF 88 at the time of entry into service, or the individual presents acceptable medical evidence that this condition did exist prior to entry into military service. Reference paragraph 5-19h, AR 600-10.

Replacement of SF 514 Laboratory Forms

After months of preparation, a new series of laboratory forms will replace the SF 514 laboratory forms for requesting and reporting clinical laboratory tests. The Interagency Committee on Medical Records has recommended that the new forms be used in all government hospitals by 1 January 1972. The list to the right gives the individual forms that will replace each 514 form.

The 514 forms (except the Clinical Sheet) are now out of print, and the new series of forms will be available in July 1971. As soon as the new forms are printed, 20 of the large hospitals will automatically receive an initial distribution of approximately two months supply. The new forms and the old forms CANNOT be used interchangeably; a complete changeover must be made at one time throughout the entire hospital. Each hospital will determine when it will change over to the new forms, prior to 1 January 1972. Hospitals that do not receive the initial distribution are advised to continue using the present forms until their supply is exhausted but, in the meantime, they should order the new forms and have them on hand.

The laboratory forms were revised to include most of the newer laboratory tests and to simplify work for the physicians, the nursing staff, the laboratory personnel, and the offices that maintain the patients' records. The accompanying illustration shows the format of the forms, and the numbers point out the different items that are described below.

Lab Form Description

When requesting laboratory tests, the hospital staff fills in the appropriate laboratory form with identifying information as to the patient, the specimen, the requesting physician, and the specific test(s), as follows:

1. *Patient Identification Data.* This information must be listed correctly and completely to assure professional and legal thoroughness in carrying out treatment for the patient. The patient data, as listed below, will be completed by the physician ordering the test or the medical staff with ink pen, typewriter, or utilization of the mechanical imprint method with the ward plate or patient's recording card:
   a. Patient's name
   b. Register number and/or FMP/SSAN
   c. Treating facility
   d. Ward number of clinic
   e. Date the test is requested
2. *Requesting Physician's Signature.* The name of the physician ordering the test will be clearly identified in the space marked REQUESTING PHYSICIAN'S SIGNATURE. In the Army medical facilities, there is no need for the physician to sign each laboratory request, but his name must be clearly identified.
3. *Urgency (Routine, Today, Pre-Op, Stat).* This is indicated by checking in the appropriate box. Note that this information is not on SF 553 or SF 554.
4. *Patient Status (Bed, Ambulatory, Outpatient).* This is indicated by checking in one of the three boxes labelled Bed, Ambulatory, or Outpatient. The terms of NP and Domiciliary are not used for patient status in the Army hospitals.
5. *Specimen Source.* This is indicated by checking in the appropriate box or by writing in the information. Other alternate specimen information is requested on certain forms, as follows:
   a. The SF 548 (Chemistry III) lists specimen interval information.
   b. The SF 553 (Microbiology I)

and SF 554 (Microbiology II) list INFECTION information. On these forms, additional specimen information is necessary to expedite the identification of the infecting organisms and sensitivities, as follows:

(1) CLINICAL INFORMATION (Include Specimen Source)

(2) ANTIBACTERIAL THERAPY

c. The SF 556 (Immunohematology) lists OBSTETRICS information for appropriate specimens.

6. *Specimen Taken.* When the specimen is taken by the hospital staff, the date and time are written on the form.

7. *Results Requested.* Each test requested is indicated by placing an "X" in the block in front of the test name. For tests that are not listed, the names should be written at the bottom of the list.

Lab Staff Procedures

After receiving the request form, the laboratory staff completes the balance of the information about the specimen and results as follows:

8. *Specimen Taken.* The date and time that the specimen is taken will be written in the space at the lower left corner of the form when the specimen is taken by the laboratory personnel.

9. *Specimen/Lab RPT NO and Lab ID NO.* The specimen and the request form may be identified and monitored in the laboratory by the specimen/laboratory report number, and the laboratory identification number placed in these spaces at the the upper right corner of the form.

10. *Results.* The results for each of the tests performed will be written or stamped in the appropriate space in the area at the bottom of the form.

11. *Remarks.* Other information for physician and patient's record will be reported in the REMARKS space.

12. *Reported by.* The Chief of the laboratory will be responsible for the results on the completed report. After the correctness of the laboratory data has been verified, the report will be signed by the Chief of the laboratory (usually a physician or technologist) or his designated representative, in the space marked REPORTED BY and M.D./TECH.

13. *Date.* The date that the report is completed will be written in the space to the right of the laboratory authentication signature.

The forms have three parts; after being filled in by the hospital staff, the complete triplicate set is forwarded to the laboratory. After the laboratory reports the results on the form, the third copy is kept in the laboratory files until no longer needed. The original and second copy are returned to the requestor, and the original is filed in the patient's medical record. The duplicate copy is available as an information copy for the physician or ward.

Individual Lab Forms, Instructions

The format of the individual laboratory forms and specific instructions are described below:

1. *SF 514 (Clinical Record-Laboratory Reports).* This is a display form for mounting graphic reports, automated print-out reports, or printed reports associated with special equipment. This is also used for reports not mounted on SF 545 or SF 545a. Typical of reports displayed on SF 514 would be the densitometer tracings from electrophoresis measurements, Serum Chemistry Graphs from SMA automated analyzer equipment, and report forms from the Coulter Model S automated hematology equipment.

2. *SF 545 (Clinical Record—Laboratory Report Display).* This is a display form for mounting laboratory request and report forms. When a patient will require the same type of test several times a separate display sheet should be used for each type of test result form. In low-use situations, the various test result forms should be mounted on alternate (1,3,5 and 7) strips.

a. It is suggested that the following SF's be mounted serially on strips 1, 2, 3, 4, 5, 6 and 7:

Chemistry I, SF 546
Hematology, SF 549
Urinalysis, SF 550
Serology, SF 551

b. It is suggested that the following SF's be mounted on alternate strips 1, 3, 5, and 7.

Chemistry II, SF 547
Chemistry III, SF 548
Immunohematology, SF 556
Parasitology, SF 552
Spinal Fluid, SF 555

c. In many instances, there will be a mixed assortment of SF's to be mounted in a patient's chart. and obviously these should be mounted in the most practical sequence.

d. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the sheet (SF 545). A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.

3. *SF 545a (Clinical Record—Laboratory Report Display for SF 553, SF 554, and SF 557).* This is a display form for mounting Microbiology I, Microbiology II and Miscellaneous forms for inclusion in the clinical records. This display sheet may also be used for mounting other laboratory forms whenever it is appropriate. When a patient will require the same type of test several times, a separate display sheet

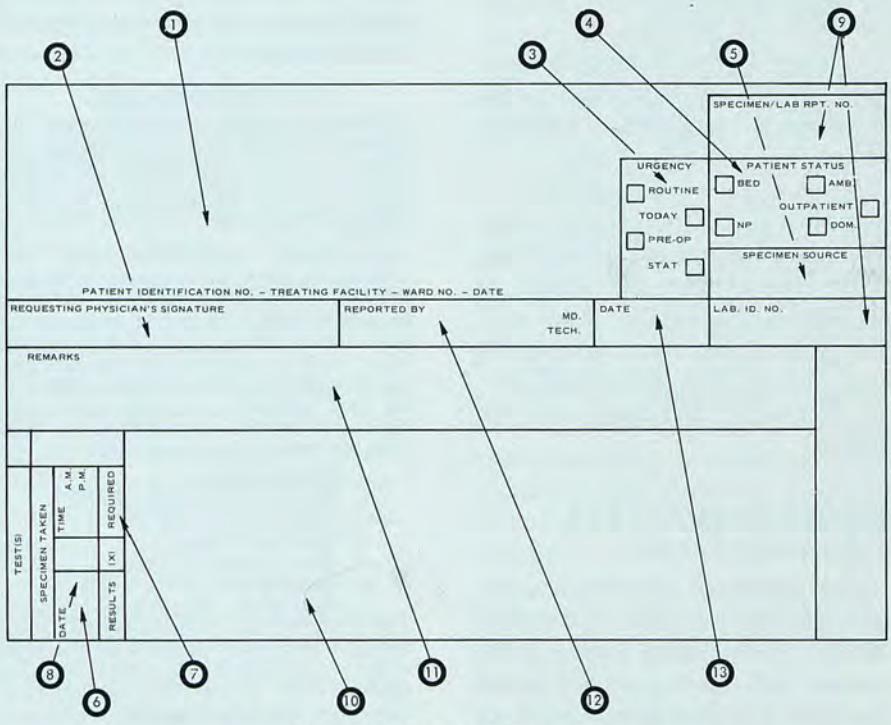


Illustration of Format of the Laboratory Forms

Present Forms		*New Forms*	
SF No.	*Name*	*SF No.*	*Name*
514	Clinical Sheet	514, 545, 545a	Laboratory Display Sheet
514-A	Urinalysis	550	Urinalysis
514-B	Hematology	549	Hematology
514-C	Serology	551	Serology
514-D	Blood Chemistry	546	Chemistry
514-F	Gastric Analysis	557	Miscellaneous
514-G	Feces	552	Parasitology
514-H	Spinal Fluid	555	Spinal Fluid
514-K	Bacteriology	553, 554	Microbiology I and II
514-L	Renal Functinos	550	Urinalysis
514-M	Miscellaneous	557	Miscellaneous
514-N	Blood Bank	556	Immunohematology
514-P	Special Chemistry	546	Chemistry
514-Q	Immunology	551	Serology

should be used for each type of test result form. In low-use situations, the various test result forms should be mounted on the same sheet. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the sheet (SF 545a).

4. *SF 546 (Chemistry I).* This form is used for requesting most blood chemistry tests. The identification data are filled in as described previously. The specimen source information is given by checking the box marked BLOOD or by supplying information in the position marked OTHER (specify). The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting this, the identifying names of the battery of tests or profile must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.

5. *SF 547 (Chemistry II).* This form is used for requesting blood gas measurement, T_3, T_4, serum iron, iron binding capacity, glucose tolerance, and other chemistry tests. The identification data are filled in as described previously. The specimen source information is given by checking the box marked BLOOD or by supplying information in the position marked OTHER (specify).

6. *SF 548 (Chemistry III [Urine]).* This form is used for requesting chemistry tests on urine specimens. The identification data are filled in as described previously. The specimen interval information is given by checking in the box marked 24 HOURS or by supplying information in the position marked OTHER (specify).

7. *SF 549 (Hematology).* This form is used for requesting routine hematology (including differential morphology), coagulation measurements, and other hematology tests. The identification data are filled in as described previously. The specimen source information is given by checking in the box marked VEIN, in the box marked CAP for capillary, or by supplying information in the position marked OTHER.

8. *SF 550 (Urinalysis).* This form is used for requesting urinalysis tests, including routine urinalysis with microscopic examination. The identification data are filled in as described previously. The specimen source information is given by checking in the box marked ROUTINE or by supplying information in the position marked OTHER (specify). Note that Routine Urinalysis may be specified by simply placing an "X" in front of the word ROUTINE at the top of the requesting section. The microscopic examination may be specified by simply placing an "X" in front of the word MICROSCOPIC in the requesting section. The space marked PSP is for requesting and reporting phenolsulfonephthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.

9. *SF 551 (Serology).* This form is used for requesting tests that measure serum antibodies, including tests for syphilis. The identification data are filled in as described previously. The specimen source information is given by checking in the box marked BLOOD or by supplying information in the position marked OTHER (specify). The space marked RPR is for requesting and reporting measurements of the Rapid Plasma Reagin card test for syphilis. The space marked TA is for requesting and reporting measurements of the latext fixation test for thyroglobulin antibodies. The space marked RA is for requesting and reporting measurements of the latex fixation test for rheumatoid arthritis. The space marked COLD AGG is for requesting and reporting measurements of cold agglutinins. The space marked ASO is for requesting and reporting anti-streptolysin 0 titers. The space marked CRP is for requesting and reporting measurements of C-reactive protein. The space marked FTA-ABS is for requesting and reporting the fluorescent treponemal antibody-absorption test. The space marked FEBRILE AGG is for requesting and reporting measurements of febrile agglutinins. The space marked COMP FIX is for requesting and reporting complement fixation tests. The name of the specific antibody should also be written in this space. The space marked HAI is for requesting and reporting hemagglutination-inhibition tests. The name of the specific antibody should also be written in this space.

10. *SF 552 (Parasitology).* This form is used for requesting tests for intestinal parasites, malaria and other blood parasites, as well as most tests on feces. The identification data are filled in as described previously. The specimen source information is given by checking in the box marked FECES or BLOOD or by supplying information in the position marked OTHER (specify).

11. *SF 553 (Microbiology I).* This form is used for requesting most bacteriological isolations and sensitivities. The identification data are filled in as described previously. The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right-hand area of the form. The examination requested is indicated by checking in the boxes marked SMEAR, SENSITIVITY, CULTURE or COLONY COUNT. The report of the examination is written or stamped on the form by the laboratory personnel. The names of the bacteria identified and/or isolated are listed in the space marked PREDOMINANT ORGANISM(S). The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.

12. *SF 554 (Microbiology II).* This form is used for requesting tests for fungi, acidfast bacteria (TB), and viruses. The identification data are filled in as described previously. The type of the patient's infection according to origin is indicated by checking one of the boxes in the space marked INFECTION. The examination(s) requested are checked in the sections for fungus tests or AFB tests or viral cultures. The test results are stamped or written on the form by the laboratory personnel.

13. *SF 555 (Spinal Fluid).* This form is used for requesting most spinal fluid tests. The identification data are filled in as described previously. An additional SF 553 or SF 554 (Microbiology I or II) is required when requesting bacteriological studies on spinal fluid specimens since bacteriological cultures must grow at least twenty-four hours before the results can be observed. The additional request form provides complete identification of the specimen without interfering with the immediate return of the cell count and chemistry results to the physician. An additional *SF 557 (Miscellaneous)* is required when requesting electrophoresis measurements since they take many hours to complete, and the report is a tracing by a densitometer on special paper. The additional request form provides adequate identification of the specimen and permits the cell count and chemistry results to be returned immediately to the physician without waiting a couple of days for the electrophoresis results to be completed.

14. *SF 556 (Immunohematology).* This form is used for requesting blood grouping, typing, and blood bank tests. This *form is not used* as a *request* to *crossmatch blood.* Requests for crossmatching blood will use *SF 518 (Blood Transfusion).* The identification data are filled in as previously described. The source of specimens from obstetric patients is given by checking in the boxes on the form.

15. *SF 557 (Miscellaneous).* This form is used for requesting tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms. The identification data are filled in as described previously. The specimen source is specifically described in the space marked SPECIMEN SOURCE. The name of the test requested is written in the request section of the form.

Third Copy Included

One of the biggest changes was including a third copy of the form to help those hospitals where the additional copy would increase efficiency. The use of pressure sensitive copy paper was considered but such papers are not yet good enough to avoid smearing and bad copies. When the forms were user tested in 1969, they had detachable labels for the specimen containers and the third copy has special information for use in data processing machines.

The hospitals testing the forms found only minimum usefulness from the label and the data processing so they were discontinued. Also, consideration was given to changing the hematology form so that it could be used with the Model S Coulter counter but that was impossible.

Thus, the planning committee looked into all of the possibilities when drawing up the forms and arrived at the best design for all the government hospitals. The description and instruction for these forms will also be printed and distributed as Change 10 to AR 40-2.

Veterinary Services

BG Wilson M. Osteen, VC, Asst. for Veterinary Services

AR 700-81 Published

AR 700-81/AFR 400-8/OPNAVINST 10570.1/MCO 10570.1, "DOD Dog Program," which establishes basic policies and principles governing logistic support of the DOD Military Working Dog Program, was published 5 May 1971. This regulation supersedes AR 715-31, Sentry/Scout Dogs, 3 September 1965. All Veterinary Corps officers providing care for Military Working Dogs should be familiar with the contents of paragraph 8, "Redistribution and Reporting of Excess Trained Military Working Dogs" (RCS:HAF-S154).

TB MED 262

TB MED 262/NAVMED P-5067/AFR 163-7, "Veterinary Food Inspection Procedures for The Inspection of Milk and Milk Products in Bulk Dispenser Containers," 15 March 1971, was distributed to the field during April 1971. This publication updates the previous publication dated 16 September 1960 and expands the procedures cited therein to include all bulk dispenser containers. Further, it provides specific references to Supplement A, Procurement Quality Assurance for Fresh Dairy Products, DOD Quality and Reliability Assurance Handbook No. H-57.

Army Dogs Returned from RVN

Redistribution of Army dogs which are excess to Army requirements in the Republic of Vietnam began in May 1971 with the shipment of 50 German Shepherd Scout Dogs and 14 Labrador Retriever Tracker Dogs to Lackland Air Force Base, San Antonio, Tex. These animals became excess as a result of the withdrawal of Army units from Southeast Asia and will be redeployed by the DOD Dog Center, Lackland, AFB, to meet worldwide requirements for military dogs.

All military dogs declared excess are given comprehensive physical examinations which include hematological examinations for evidence of *Tropical Canine Pancytopenia* (TCP). Dogs which have never had clinical TCP, or been classified as TCP suspects and which successfully pass the final physical examination are considered eligible to be redistributed. These dogs are placed in a quarantine facility in RVN and as an additional safeguard, are administered not less than a 14-day course of oral tetracyclne (the drug of choice for treatment of TCP) at a rate of 50 milligrams/pound of body weight/day, during the quarantine period.

New Irradiated Food Studies Initiated

The Department of the Army has been directed by Congress to pursue a multi-million dollar research program to evaluate the wholesomeness of irradiated foods. To provide the overall monitorship of contractual studies for wholesomeness evaluation of irradiated foods, LTC Roger W. Baker, VC, has been assigned to HQ US Army Medical Research and Development Command as Special Project Officer for Irradiated Foods.

To date, an animal feeding study protocol has been written to comply with current Food and Drug Administion regulations that require the safety and wholesomeness of the test food to be demonstrated in three species of animals.

A four-year research contract has been awarded to evaluate food consumption, weight gain, feed efficiency, hematology, certain enzyme studies, urology, reproductive performance, longevity, ophthalmology, and gross and microscopic pathology in mice, rats and dogs.

War Against Weevils

For many years, the U.S. Armed Forces have sustained food losses resulting from insect infestation. Although the problems were repetitive and the total losses significant, frequently the incidence was scattered, involving relatively small quantities of product at a given installation; reporting was incomplete; and the problems were managed at a local level. However, the extensive degree of infestation, with subsequent large scale condemnation of flour and similar food products recently experienced in Southeast Asia, served to focus sufficient attention on the problem to stimulate coordinated corrective action. In September 1967 a coordinated Pest Control Program was initiated by the Defense Personnel Support Center, (DPSC) Philadelphia, Pa. 19101, with the assignment of LTC George H. Wyckoff, VC as its project officer.

A review of then-current control procedures and a survey of infestation incidence, both in CONUS and overseas, re-established two basic facts regarding infestation in military subsistence: First, there is no one single source of infestation. It may occur at any or all of the various stress points in the military supply chain.

Second, there is no one single control measure that is a panacea for infestation problems. Effective control requires a program approach designed to limit/prevent infestation at all stress points in the supply chain.

Also, this review revealed that not only was reinfestation of the same commodity occurring at an alarming frequency, but the repeated application of standard control procedures produced chemical residues that imparted sufficient odor and taste to the product to render it unpalatable and unserviceable. In other words, the control procedures were stressing the

product as much as the insects were. Further, recommendations by the Armed Forces Pest Control Board, (AFPCB), concerning the application of improved packaging and shipping containers and tighter processing restrictions were not sufficient in themselves to afford that degree of protection of the products from infestation during periods of transportation and storage required by the military services.

The environmental conditions encountered in Southeast Asia were optimum for rapid insect development. During 1967-1969, reported condemnations of infested cereal products average 3-4 million annually. Subsistence personnel at HQ USARV estimated food losses from insect infestation would be in excess of $6 million in 1970.

Recent research conducted at U.S. Army Natick Laboratories, Boston, Mass., in support of a DPSC research proposal, revealed that the secretions of certain insects (Tribolium sp.) commonly encountered in military subsistence infestation, dramatically reduce the quality of the baked end-product thus adding to the problem. Significantly, these changes are irreversible and can occur before any effect on the flour or other cereal products can be detected by gross inspection.

A systematic appraisal of insect control procedures at all stress points in the logistical chain revealed the need for an efficacious, efficient, economic, residue-free commodity fugigant that could be applied safely and simply, with a minimum of equipment and training, to railcars and depot storage facilities.

A relatively new fumigant, aluminum phosphide (Phostoxin, Degesh, Frankfort [Main] Western Germany) was field tested at the Naval Supply Center, Norfolk, Va., during August 1968, under the direction and supervision of Army veterinarians. This fumigant is formulated as a solid in tablet or pellet form. Hydrogen phosphide (PH_3) is evolved by hydrolysis upon exposure of the formulation to atmospheric moisture. Food and Drug residue tolerances, and clearance for use on all processed foods were granted in September 1967.

Results of the Norfolk field test prompted approval by the Armed Forces Pest Control Board in September 1968 for military application. Subsequently, in May 1970, aluminum phosphide was designated the fumigant of choice for military subsistence; an "in-place" fumigation program was implemented for all CONUS subsistence supply depots in July 1970; and DPSC developed an in-transit fumigation program for rail shipments of flour which was initiated in August 1970.

As a result of a direct request for assistance from USARV, special aluminum phosphide field fumigation kits were developed by the AFPCB and in August 1970 an AFPBC fumigation team, including Colonel Wyckoff, went to RVN to provide training in the aluminum phosphide "in-place" fumigation method, and to assist in establishing the first in-country stored product pest control program.

One-week training symposiums were conducted for Class I depots at Long Binh, Cam Ranh Bay, Qui Nhon, and Da Nang. Trainees included both Vietnamese and third country nationals to permit continuation of these programs when U.S. forces are withdrawn. In addition, the fumigation team conducted similar programs at Okinawa and Hawaii.

Implementation of this new, highly effective control program has proved to reduce significantly insect infestation in processed cereal products. As a result of a successful pilot program with flour, DPSC extended, effective 1 May 71, the in-transit fumigation requirements to include noodles, macaroni, spaghetti, and cornmeal. At the Naval Supply Center, Norfolk, Va., the incorporation of new techniques employing aluminum phosphide fumigation has resulted in 98 per cent reduction in insect infestation problems.

For further details concerning this program, the attention of all U.S. Army Medical Department personnel is invited to MIL-STD-1486, In-Transit Fumigation, 6 May 1970; The Armed Forces Pest Control Board, Technical Information Memorandum Number 11, "Aluminum Phosphide, Formulated and Fumigation or Famine," Wyckoff, G. H. and Anderson, R. D., J.A.V.M.A. Vol 157, No. 11 (1970): 1828-1834.

Directorate of Personnel & Training

COL Floyd W. Baker, MC, Director

Authorized Absences for Students

Many AMEDD students in long-term civilian schooling, especially those in the Walter Reed Army Institute of Nursing and the Army Student Nurse Program, are not completely aware of the provisions of AR 30-5, "Leave, Passes, Administrative Absence and Public Holidays."

A lack of understanding of the different types of authorized absences can cause personal hardships for students in civilian institutions. If you are now in school, be sure to contact

your student detachment before taking any absences that might affect your status. If you will be attending a civilian institution in the near future, become familiar with the provisions of AR 30-5.

Personnel officers should insure, at the time of out-processing, that officers on PCS orders to civilian institutions are briefed on authorized absences.

Procurement Needs for MSC/VC FY 72

Direct commissions will be offered in the following MSC specialties during FY 72: Optometry, Social Work, Sanitary Engineering, Environmental Sanitation, Immunology, Pharmacy, Podiatry and Military Community Oral Health Management.

Only a limited number of pharmacy and podiatry spaces are available for direct appointment; thus, the program will be highly competitive. About 45 spaces are available for direct appoinments in the Veterinary Corps with input in either the September 1971 or January 1972 basic classes.

AMEDD Training Publications

Army Medical Department officers who apply for training should be familiar with at least two publications available throughout the United States Army:

• *AR 350-219,* "Professional Training of Army Medical Department Personnel." This AR governs training of AMEDD personnel at Army health service facilities, schools of other Army components, non-Army Federal facilities, and civilian educational, commercial, and industrial institutions.

The regulation prescribes policy, lists procedures, and states prerequisites for the education or training. The regulation is currently under revision and it is anticipated it will be released by the publishers in time to become effective FY 1972. One of the major changes in the regulation is the promulgation of a single form for all applications for schooling.

• *AMEDD Course Catalog.* This catalog supersedes DA Pamphlet 351-1 and the annual circular announcing the class schedules. The catalog lists AMEDD in-service professional courses and training programs which The Surgeon General recognizes as a continuing medical professional training requirement and also includes enlisted courses. World-wide distribution has been made. Corrections, changes, deletions, or suggestions for improvements should be forwarded to the Training Division, OTSG, ATTN: MEDPT-TD.

Related References

AR 1-211, "Attendance at Meetings of Technical, Scientific, Professional, and Other Similar Private Organizations."
AR 40-31, "The Armed Forces Institute of Pathology and Armed Forces Histopathology Centers." (Speciality Board Preparation)
AR 40-219, "Professional Specialty Board Certification."
AR 350-200, "Training of Military Personnel at Civilian Institutions." (less AMEDD)
AR 60119, "Army Student Nurse, Dietitian, and Occupational Therapist Programs."
AR 601-112, "Program for Medical, Ostheopathic, Dental and Veterinary Education for Regular Army Officers."
AR 601-130, "Medical, Ostheopathic, Dental, and Veterinary Senior Student Programs and Other Professional Training Programs."
AR 601-138, "Medical Service Corps Graduate Student Program."
AR 601-140, "Medical Department Early Commissioning Program."
AR 601-235, "Walter Reed Army Institute of Nursing Program."
AR 621-5, "General Educational Development." (Degree completion)

AMEDD Labor Relations

Labor relations within AMEDD are "healthy." Over past years, such activities have been exercised in a spirit of cooperation and significant progress has been made in this area.

We have been fortunate, to date, in being free of problem situations except in a few isolated cases. So far the AMEDD has been involved in only one arbitration case, in which the arbitrator supported local management decisions. In a similar situation, two unions at an AMEDD hospital were parties to a jurisdictional dispute settled at union headquarters level without direct management involvement.

The Hdqs union decision did, however, support local management's original decision with respect to the unions concerned. This is a reflection of what has gone on in the past; it is not a prediction for the future.

The AMEDD has been operating under Executive Order 11491 for more than a year during which there has been considerable maneuvering by the national unions.

Little of this activity has filtered to local AMEDD levels. We have, of course, seen some of the effects of EO 11491 in the contracts most recently negotiated. Only in the past six months has significant national activity been evident, demonstrated by decisions of the Federal Labor Relations Council, the Federal Services Impasses Council, and the Assistant Secretary of Labor for Labor-Management Relations. So far, most of these decisions have been highly technical and procedural, and as yet none has significant impact for AMEDD installations. But precedents are being, and will be, established that will have a profound effect on government labor relations activities. We can expect ever increasing union activity in coming months.

The following statistics give an up-to-date picture of labor relations in AMEDD. Throughout the federal government, 58 per cent of the employes are now covered by exclusive recognition. Excluding the Postal Service, probably the most highly organized government agency, the recognition figure is 48 per cent. Within Department of the Army, 47 per cent of employes are covered by exclusive recognition; within AMEDD, 44 per cent. We expect a continuing increase in union coverage of AMEDD employes.

Within AMEDD, of those employes covered by exclusive agreements, 56 per cent are blue collar and 44 per cent are white collar. Professional employes are uncovered with one exception, the non-supervisory Occupational Health Nurses in the U.S. Army Civilian Employe's Health Service in the Washington, D.C., area. This group comprises 35 professional

nurses for whom a contract is now being negotiated.

All AMEDD Class II hospitals and centers are organized to some extent. Madigan and William Beaumont are completely covered while Fitzsimons is fully organized except for two AMEDD tenant agencies—OCHAMP-US and the Nutrition Laboratory. At Madigan and William Beaumont Hospitals the coverage is over 70 per cent. The rest are supervisors and professional workers. Valley Forge has roughly 50 per cent coverage; Letterman, 33 per cent; Brooke, 34 per cent; and Walter Reed about 25 per cent.

There are now 25 exclusive and 14 formal recognition units in the AMEDD. Formal recognition ended about 1 July 1971. Such formal recognition has been extended to the Exchange Service employes at Walter Reed Army Medical Center. This is the only non-appropriated fund employe union activity that has occurred within AMEDD. It will not be surprising to see added organizational work among NAF employes in the future.

Seven different union organizations have exclusive representation in AMEDD. The American Federation of Government Employes (AFGE) is by far the largest, representing about 40 per cent of AMEDD employes in 18 units in all of our AMEDD Class II installations and activities.

Engineering Courses at AMEDD Installations

Through the cooperation of the U.S. Army Management Engineering Training Agency (AMETA), The Office of the Surgeon General, the Presidio of San Francisco, and two AMEDD installations, two AMETA courses were recently conducted for civilian and military personnel.

The two courses were held at Brooke Army Medical Center and Letterman General Hospital, instead of Rock Island, Ill.

These arrangements brought considerable TDY savings and made more spaces available to the command for AMEDD personnel than ever before at Rock Island.

At Brooke Army Medical Center, from 7-11 December 1970, AMETA conducted the Automatic Data Processing Appreciation Course, a one-week orientation designed to enable managers to participate in ADP planning, development, and utilization. Twenty-one officers and six civilian employes of BAMC completed the course, while four officers and four civilian employes from OTSG and other AMEDD installations also attended. This course was also conducted at BAMC in 1969.

At Letterman General Hospital, from 18-29 January 1971, AMETA presented the two-week Systems and Procedures Analysis Course, designed to provide management and systems analysts with the techniques of management of information and administrative systems and procedures. The West Coast location enabled 30 personnel to attend. The course included military and civilian participants from The Presidio of San Francisco, Letterman General Hospital, Walter Reed Army Medical Center, Madigan General Hospital, William Beaumont General Hospital, and the U.S. Army Materiel Agency.

Kudos to WBGH's Healthy Employes

A recent ceremony at William Beaumont General Hospital reflects the degree to which Beaumont personnel are contributing to off-set the undesirable trend of increased sick leave usage by DA employes.

BG Robert M. Hardaway III, MC, WBGH commander, welcomed 24 employes to the "2,000-Hour Club" and presented each with a certificate of recognition. Earlier, 100 employes received certificates for accumulating 1,000 hours of sick leave credit. A high proportion of those honored in both groups were Spanish-surnamed employees.

During the last three years William Beaumont has consistently maintained a highly favorable annual sick leave rate. In all, about 18.5 per cent of the WBGH civilian work force has accrued 1,000 or more hours of credit. Although no dollar value can be placed on dependability, so important to the patient care mission, the hospital estimates the accumulated civilian sick leave value at about $1,887 per employe. The saved sick leave represents a cash savings to the hospital of some $1.5 million (the estimated cost of salaries had the sick leave been used).

The civilian personnel officer, William R. Frank, credits the El Paso climate for much of this achievement, but full recognition and appreciation is given to the conscientious employes who attained this distinction, and to their supervisors who are effectively exercising their responsibility for administering sick leave.

Recent Key Assignments in WRAMC Civilian Personnel Office

John DEL CECATO was recently assigned as Chief, Management Employe Relations Section, and Ernest M. WILLCHER assumed the position of Chief, Recruitment and Placement Section, in the Civilian Personnel Office at Walter Reed Army Medical Center.

Del Cecato was formerly assigned to the Chicago Field Office of the Deputy Chief of Staff for Personnel, Department of the Army, and Willcher joined the WRAMC office after serving with the U.S. Army Topograpic Command, Washington, D.C.

AMEDD Handicapped Employes Recognized

Two AMEDD employes have rereceived honorable mention in the Department of Army's search for the Outstanding Handicapped Employe for 1970.

H. Keith Russell, winner of the Walter Reed Army Medical Center Handicapped Employe of the Year Award for 1970, and Harold F. Combs, the nominee recommended by William Beaumont General Hospital, were among five Army civilian employes honored.

Russell and Combs received congratulatory letters from Donald W. Srull, the Acting Assistant Secretary of the Army (Manpower and Reserve Af-

fairs) and from LTG Hal B. Jennings, Jr., The Surgeon General.

Russell, a paraplegic, is employed as Chief, Geographic Pathology Laboratory Branch, Histopathology Laboratories Division, AFIP, occupying the position of Supervisory Histopathology Technician.

Combs, a Physical Science Technician in the Department of Medical Research and Development at William Beaumont General Hospital, is totally deaf and has a medically controlled hypertension handicap resulting from an acute myocardial infarction.

Despite these physical limitations, these men have not only made significant contributions to their fields of work, but also have records of laudatory achievements in their tireless efforts in behalf of other handicapped people. Neither began life with handicaps.

Because of the enlightenment expected of military and civilian managers of AMEDD regarding the abilities of even severely handicapped people, this command should lead Army in the proportion of physically handicapped individuals employed. Although AMEDD had not yet achieved this desired distinction, pride can be taken in the high quality of severely physically handicapped civilians exemplified by Russell and Combs.

In recent years several exceptional AMEDD employes have met the criteria for nomination for the DA Handicapped Employe of the Year Award. Miss Magdalene Phillips of Letterman General Hospital received the award for 1969.

All AMEDD personnel join in saluting Russell and Combs and the many other employes who perform their jobs creditably despite physical handicaps.

MGH Receives Army Award

BG John Boyd Coates, Commander of Madigan General Hospital, received an Army plaque symbolic of the award to the hospital for having the best suggestion program in the Medical Department for Fiscal Year 1970. The presentation was made by LTG Hal B. Jennings, Jr., The Surgeon General, at the Joint Commanders' Conference held in Washington, D.C., last April.

The criteria for judging this award are the numbers of military and civilian suggestions submitted and adopted, the dollar savings per dollar awarded for adopted suggestions, the degree to which the number of suggestions remaining on hand without final decision are kept to an acceptable level each quarter, and the amount and nature of local promotion effort.

Madigan General Hospital was the third Army Medical Department installation to receive this recognition. Winners of this award for previous fiscal years are Brooke Army Medical Center, 1967 and 1968, and William Beaumont General Hospital, 1969.

Long-Term Training— Fiscal Year 1972

Two Army Medical Department civilian employes have been approved for long-term training support from the Department of the Army central pool of funds and manpower spaces during FY 1972.

Alan Chee, architectural engineering technician at Walter Reed Army Medical Center, has been approved to begin the second of a three-year program in architecture at Howard University School of Engineering and Architecture, Washington, D.C.

John F. Schrot, research psychologist, Walter Reed Army Institute of Research, has been approved for a one-year program in psychological investigation at American University, Washington, D.C.

To qualify for support, proposals for long-term training must have high potential value to the Department of the Army and be related to the individual's current or future responsibilities. Further details regarding nominations under this program may be found in Civilian Personnel Regulation 400, Subchapter 410.12, and obtained from Civilian Personnel Offices.

Civilian Personnel Officer Conference

Civilian Personnel Officers from the major AMEDD Class II medical centers and hospitals met in Arlington, Va., 23-26 March 1971 to discuss the status of the AMEDD civilian personnel program and to plan improvements.

Also in attendance at the conference were members of the staff of the Civilian Personnel Division, OTSG, and a representative of the Health Care Administration Division, USAMFSS.

MG Spurgeon Neel, MC, welcomed the conferees on behalf of The Surgeon General. The group was also addressed by Charles F. Mullaly, Director of Civilian Personnel, DA; by officials of the Office of Civilian Personnel, DCSPER; and by MAJ Donald M. Graydon, MSC, ADP Systems Division, Office of the Comptroller, OTSG.

Topics at the conference included special employment programs, labor relations, equal employment opportunity, ADP applications to civilian personnel administration, new grievance and appeal procedures, and program planning, evaluation, and feedback to managers.

Secretary of the Army Research and Study Fellowships

Two AMEDD civilian employes have been awarded Secretary of the Army Research and Study Fellowships.

Dr. Howerde E. Sauberlich, Chief of the Chemistry Division, U.S. Army Medical Research and Nutrition Laboratory, Fitzsimons General Hospital, will soon complete a fellowship in new techniques and concepts of human nutrition, clinical investigation, and nutritional biochemistry and toxicology at Vanderbilt University, Nashville, Tenn.

In addition, Leo Kazyak, research chemist at the Walter Reed Army Institute of Research, Washington, D.C., was recently awarded a fellowship to establish an international cooperation program in data exchange and computerized retrieval facilities information on compounds of toxicological interest. He will work at the

Central Research Establishment, Aldermaston, England, and other U.S. and foreign laboratory facilities in Europe from 15 June 1971 to 15 June 1972.

The Secretary of the Army Research and Study Fellowships make it possible for outstanding career civilians to make substantial contributions to Army programs through completion of study and research projects. They also provide unusual opportunities for increasing personal capabilities. Proposed projects under this program must have high potential value to the Department of the Army, and may include periods of 6-12 months of full-time study and research in connection with a specific project.

Details about standards and requirements for fellowship applications are described in Appendix E, Civilian Personnel Regulation 400, Subchapter 410, or may be obtained from civilian personnel offices.

Dental Services

MG Robert B. Shira, DC, Ass't for Dental Services

PROFESSIONAL ACTIVITIES

Pre-Specialty Clinical Rotation Program

On 2 July 1971 a prototype pre-specialty clinical rotation program was established at selected Army installations. The program provides an opportunity for exceptional non-career dental officers to undergo a one-year supervised, comprehensive clinical experience as a possible prelude to entering on extended active duty and receiving specialty training.

Objectives of the program are:

- To provide a sound general dentistry background for potential career officers.
- To evaluate officers' potential for specialty training.
- To provide officers an opportunity to evaluate their own preferences in regard to specialty training.

If the program works out as anticipated, it is expected it will be extended Army-wide during FY 1973.

Officers completing the second year of obligated service are the primary candidates for the program, although officers with more than two years service may be considered on an individual basis. Officers who have completed an internship are not eligible. Nominations for participation in the program are made by Dental Surgeons or Chiefs of Hospital Dental Service. Participation carries no pay-back commitment. Applicants need only extend on active duty through the completion date of the program which is 30 June of the year following the 1 July starting date.

Officers approved for participation in the prototype program will receive training at their current duty stations. Training will consist of rotation through all of the major specialty areas (Oral Surgery, Periodontics, Fixed and Removable Prosthodontics), plus other specialty areas (Endodontics, Pedodontics, Orthodontics, Oral Diagnosis, and Preventive Dentistry), in which the participant expresses an interest and/or in which a qualified mentor is available. Specialty areas in which the participant expresses particular interest will be scheduled early in the rotation program.

The chief of each specialty service involved in the program will be asked to forward to OTSG an evaluation of each trainee's suitability for advanced training as he finishes his rotation in that specialty area. A final evaluation of each officer in the program will be required between 1 and 31 March of the training year. At that time the qualifications of each trainee will be reviewed and the future requirements of the service determined. Within the parameters of service requirements, officers with demonstrated proficiency in the specialty area of their choice will be offered a career pattern leading to training in that specialty; generally within one year, but in the case of a heavily sought-after specialty, probably within two years subsequent to the completion of the Clinical Rotation Program.

Should no requirement be forecast, or the officer be found unsuitable for further training in the specialty area of his choice, he may be offered training in another specialty area to include the specialty of General Dentistry.

If an officer has performed unsatisfactorily during the training period, or is not interested in the career pattern, he will be separated from active duty upon completion of the program.

Officers who want to pursue the career pattern offered will be required to apply for career status—Voluntary Indefinite or Regular Army. They then will be programmed into one of the two yearly classes of the AMEDD Officer Career Course. This will be done either by sending them directly to the Medical Field Service School for Class No. 1 and having them report six months early to their advanced training site, or by keeping them at their current location for an additional six months, then sending them to Class No. 2, and then to their advanced training site.

More information on the pre-specialty clinical rotation program will be

published as experience is gained with the prototype program.

Review of Professional Articles

The Executive Office section of this *Newsletter* specifies a new policy and procedure for review and clearance of professional articles intended for publication.

However, articles involving Army-wide dental service policies or programs will be submitted to the Surgeon General, DA, ATTN: MEDTL, Washington, D.C. 20314, for clearance.

Children's Self-Application of Preventive Dentistry Paste

Several ideas for improving the effectiveness of self-application programs for children submitted to this office by LTC Russell S. Norris, Preventive Dentistry Officer, Fort Riley, Ka., are as follows:

Have younger children practice taking mouthfuls of water, swishing the water around, then spitting it out into the dry cup provided until each child can do this without swallowing. (This approach has been reported to be completely effective in eliminating nauseous reactions to use of the paste).

Do not hold up a whole group of children because of one or several children who cannot keep up with the group. Point out such children to trained assistants who can then help them individually. This eliminates the need for those who can keep up with procedure having to wait and thereby increasing the likelihood of their swallowing the paste.

Have all materials that are to be disposed of placed into large plastic refuse bags immediately following the self-application. Have the bags tied shut, and removed from the room to eliminate any odors that might contribute to nauseous feelings.

Patient Education Device

The photo below shows an idea submitted to LTC David E. Layman, Preventive Dentistry Officer, Madigan General Hospital, for modification of a hand-held patient education device into one which frees the hands for flossing exercises.

FLASHLIGHT MIRROR: This teeth-cleaning aid uses a standard Army flashlight with a detachable base and mirror.

Radiation Protection

The Oklahoma State Dental Association publishes an excellent reference manual entitled "Radiation Protection and Safety in the Dental Office." Copies of this manual may be obtained at a cost of $1 each from:

Oklahoma State Dental Association, 222 Plaza Court Building, Oklahoma City, Okl. 73103.

PLANS AND OPERATIONS

Dental Combat Effectiveness Program

The officer in charge of the dental clinic located at Oakland Army Base reports that up to 40 men per month enroute to Vietnam seek treatment at his clinic for dental conditions requiring treatment prior to overseas departure.

Many of these men require extensive care which necessitates placing them on dental hold, and in a number of instances they say they were told their care could better be provided at Oakland than at the installation where they received orders.

To correct this situation, the Oakland Clinic will furnish this office with detailed information on patients enroute to Vietnam who require treatment more extensive than can be provided in a single appointment. This information will be forwarded to the appropriate Dental Surgeon or Chief of Hospital Dental Service for follow up and necessary action.

Legislation of Interest to DC Officers

Senate:

S-853: To establish a military medical college and to provide premedical courses at U.S. Service Academies. S-1078: To provide for defense of certain malpractice and negligence suits brought against members of the Armed Forces for alleged acts or omissions committed while performing duties as physicians, dentists, nurses, pharmacists, and other paramedical personnel.

House of Representatives:

HR 2: To establish a Uniformed Services University of the Health Sciences.

HR 578: To provide for establishment of a U.S. Armed Forces Medical School and later inclusion of a dental school and to establish an Armed Forces health professions scholarship program.

HR 1013: To provide additional dental care for dependents of members of the Uniformed Services.

TR 1408: To provide additional dental care for dependents of active duty members of the Uniformed Services.

HR 2526: To provide medical and dental care for dependents of certain members of the Uniformed Services for a period of 90 days after the date of separation of such members from active duty.

Team HA, Dental Service Detachment

Experiences in Vietnam with KJ teams have indicated that these units lack essential components in their tables of Organization and Equipment.

To correct these deficiencies, a new TO unit, the HA team, has been developed. The new unit is authorized additional generator power sufficient to operate high-speed handpieces, and has an enlisted complement of 40 men instead of the 21 in the KJ team.

The first HA detachment to be activated in the Army is now at Fort Jackson, S.C., with LTC Wilbur W. Strong as commander. It has been designated the 257th Medical Detachment, Dental Service, in honor of the oldest KJ team to have been deactivated in Vietnam up to now. The original 257th served in Vietnam from November 1965 until its deactivation in late 1969.

Two additional HA teams are being formed in Vietnam by consolidating three KJ teams.

Automated Military Outpatient System (AMOS)

Since September 1969, a program has been under way at Fort Belvoir to develop a system of automating, as much as possible, the delivery of outpatient medical care in military health facilities.

Although this project, designated AMOS, has heretofore been exclusively aimed at improving the delivery of medical care, an investigation into its applications to dentistry is now being planned. A dental officer will be assigned full-time to the project beginning in the summer of 1971.

St. Louis Regional Dental Activity

As of 15 May 1971, the Regional Dental Activity at St. Louis discontinued accepting new prosthodontic cases from its customers. It was officially closed 30 June.

The workload previously handled at St. Louis has been redistributed among the RDA's at Brooke Army Medical Center, Alameda, and Walter Reed Army Medical Center. The men of the RDA at St. Louis have provided an outstanding service for many years, and it is regrettable that economic and organizational requirements necessitated this move.

Single Concept Films

Following is the current status of the Single Concept Film Program.

Distributed to all Installations:

(1) 8D-17-R—Anatomic Landmarks in Panorex Radiography.
(2) 8D-46-PE—Laterally Positioned Flap in Periodontics.
(3) 8D-23-FP—Horizontal Pin Splinting for Anterior Teeth.
(4) 8D-55-S—Surgical Reduction of the Maxillary Tuberosity.
(5) 8D-38, Panographic Diagnostic Pathology, Radiolucencies—Part I.
(6) 8D-39, Panographic Diagnostic Pathology, Radiolucencies—Part II.
(7) 8D-40, Panographic Diagnostic Pathology, Radiopacities.

Distributed to Installations Conducting Oral Surgery Training Programs:

(1) 8D-47, Anatomy of the Head and Neck Lateral Neck—Superficial Structures.
(2) 8D-48, Anatomy of the Head and Neck Boundaries of the Carotid Triangle.
(3) 8D-49, Anatomy of the Head and Neck the Carotid Triangle.
(4) 8D-50, Anatomy of the Head and Neck the Tracheal Triangle.
(5) 8D-62, Anatomy of the Head and Neck Submandibular Triangle.
(6) 8D-71, Anatomy of the Head and Neck the Thyroid Area.
(7) 8D-80, Anatomy of the Head and Neck the Parotid Gland and Facial Nerve.
(8) 8D-81, Anatomy of the Head and Neck the Pharynx-Topographical Anatomy.
(9) 8D-82, Anatomy of the Head and Neck Temporo-mandibular Joint.
(10) 8D-108, Anatomy of the Head and Neck Masseter and Temporal Muscles.
(11) 8D-109, Anatomy of the Head and Neck Pterygoid Muscles and Infrapterygoid.

In Production:

(1) The Oral Examination
(2) Taking the Medical History
(3) Provisional Fixed Partial Denture Techinque
(4) Intravenous Premedication
(5) Immediate Treatment Dentures for Full Arch Extraction

On Order:

(1) Dental Office Emergencies, Parts I-IV

For those who have not already made arrangements to obtain the appropriate projector, the following information is furnished:

GSA contract #—GS 00S-87100 (through Nov 71)
Fairchild Model Seventy—21—$316.
Fairchild Model Seventy—31—$319.
Fairchild Model Seventy—41—$399.

MATERIEL AND FACILITIES

Silver Alloy Pellets

In a continuing effort to provide the dental service with a broad choice of fine materials, changes have been made in the selection of silver alloy pellets available through the Federal Supply System. The dentist and his assistant need to be aware of the various alloy pellets presently available to them, and also, that the different stock numbered items have their own specific handling characteristics, mixing requirements, and physical properties.

Silver alloy pellet, FSN 6520-926-2113, is Caulk's Optaloy which is a micro-grain alloy of 325 mesh and is described as "fast setting." This material reaches an early strength and the manufacturer claims it produces a restoration with higher marginal density. To achieve the proper mercury-alloy ration of 5.8 to 5, the "OP" plunger must be used in the Caulk mercury dispenser.

Under stock number 6520-853-8346, either of two alloys may be supplied. These may be either Caulk Twentieth Century *Regular Alloy* or Caulk Twentieth Century *Fine Cut* Alloy. The T.C. Regular Alloy in the supply system is being replaced by T.C. Fine Cut Alloy and the problem of two materials under one stock number will correct itself in time. "Fine Cut" Alloy is a smooth working, fine grain material of 230 mesh which sets more slowly in the tooth than Optaloy thus providing more working time. This new "fine cut" silver should be used with the "E" plunger in the mercury dispenser for optimum results. The "E" plunger is being supplied at present in the boxes with the new alloy.

Since there are three different alloys currently available to the dentist, it is recommended that the manufacturers' instruction for proper handling of each material be followed closely. One important step is to be sure the proper plunger for the particular alloy is used in the mercury dispenser. Care in following the specific direction for each different material should help the dentist achieve the optimum characteristics of the amalgam.

Dental Light Safety Shield

A potential safety hazard has been noticed in visits to some dental clinics. The Pelton and Crane Light, Fantastic, FSN 6520-890-2184 or 6520-905-

7894, is being used in some instances without its clear plastic protective shield in place. The plastic shield covers the faces of the lamp head and is designed to prevent glass from falling on the patient, dentist and assistants if a lamp bulb should explode. On rare occasions, lamp bulbs explode for no apparent reason so the Pelton and Crain Company has provided a safety shield for their dental lights to prevent potential injury.

It appears that some safety shields may have been inadvertently discarded in the unpacking or installation procedures and therefore, were not originally installed on the lights. Any dental service requiring a replacement shield can order the item from Pelton and Crain Company, P.O. Box 3664, Charlotte, N.C. 28203. The *Shield-Lense* is part #H35-165 and has a government price of $1.50. The manufacturer also sells a *Handle Spacer Kit,* #H35-555 for 75¢ which prevents the lamp handles from becoming hot when the safety shield is used.

Dental Smocks

Some dental services have reported problems with the size of the new aqua dental smock, FSN 6532-926-9964; large size. The smock will not comfortably fit dentists who wear suit size 46 or larger.

Action has been initiated by this office to provide an extra-large size smock through the supply system. Even with accelerated procurement procedures in effect, it may require four to six months to complete this project. As an interim solution, commercially available smocks similar to the standard item can be purchased on a non-standard basis by dental services experiencing a problem.

Angelica Uniform Company, 700 Rosedale Avenue, Saint Louis, Missouri 63112, can supply smocks similar to the military standard. Smock number 87005-RBW is the 65 per cent polyester, 35 per cent cotton poplin aqua smock. Angelica stocks sizes 46 and 48 and sells them at approximately $6.40 to the government. For a slight additional charge, they can manufacture smocks up to size 54. Delivery on the custom made smocks will take four to six weeks.

Delay in Publishing 6520 Catalog

The Federal Supply Catalog C-6520-IL for Dental Instruments, Equipment and Supplies is normally published every two years. Defense Personnel Support Center, responsible for publication of the catalog, has informed this office that publication of the revised 6520 catalog due in October 1971 will be delayed until January 1972. This delay has resulted from a rescheduling necessitated by a major revision of the 6505 catalog for Drugs, Biologicals, and Official Reagents.

It is suggested that dental services be sure they receive, and are using, the latest Federal Supply Catalog Change Bulletin C-6500-IL-CB published on a quarterly basis in order to up-date their present 6520-IL catalog.

Central Oral Evacuation System Studies

The need for an adequate oral evacuation system in the dental operatory has been recognized for some time.

Unfortunately, the state of the art was not sufficiently advanced until recently to provide a central system reliable enough to meet our large clinic needs. Past installations of oral evacuation systems have led to some severe disappointments and bad experiences as far as military dental clinics were concerned. Because of these bad experiences, central evacuation systems are not currently included in the construction criteria for new clinics.

This office is now reviewing the whole subject of central evacuation systems, collecting data, and contacting industry in an attempt to find suitable systems for Army needs. Chances of finding adequate systems appear good at this time and it is anticipated that in the not-too-distant future construction criteria will call for the installation of central suction systems when our new clinics are built. As an outgrowth of this sutdy, it is also anticipated that guidelines and instructions can be developed on this subject which will aid dental services that desire to have oral evacuation systems installed in existing facilities.

To aid in the study and the collection of data, comments on oral evacuation systems are solicited from dental services which have had previous experience in the field. The comments should be addressed to this office, ATTN: MEDDS-MF.

Orthodontic Supplies

Unitek Corporation of Monrovia, Calif., has recently received a GSA contract for orthodontic supplies and equipment. The granting of this contract now provides the Army with two manufacturers of orthodontic supplies who have GSA contracts: Unitek and Rocky Mountain Companies.

The Unitek contract is No. GS-00S-89999 and runs through 30 November 1971. Unitek is presently making distribution of their GSA catalog to Army installations where orthodontists are assigned. Any other dental service requiring a GSA catalog should send a request to: Mr. Willard P. Rhodes, National Sales Manager, Unitek Corporation, 950 Royal Oaks Drive, Monrovia, Calif. 91016.

New Items

The following items of dental interest have recently been type-classified and are available through the supply system:

1. *Handpiece, Dental Contra-Angle,* FSN 6520-449-5772; Long Round Sleeve. Midwest American Catalog No. 250016, Ball Bearing FF Contra-Angle AAC "L", $62.00 for Latch burs, and for use with Midwest Tru-Torc.

2. *Wax, Dental Baseplate,* FSN 6520-449-5773; medium 1 lb. box, $1.75. Ribbon form pink ax, rolled in dispenser carton; for occlusal registration and setting up artificial teeth. Roll-O-Wax from Dentsply.

3. *Explorer, Dental Endodontic* FSN 6520-193-8979, No. DG 16A and FSN 6520-193-8980, No. DG 16B. For exploration and debriedement of pulp chambers and canals during endodontic procedures. Star Dental Manufacturing Company.

4. *Processing Machine, Radiographic Film,* FSN 6252-484-9490, Automatic. AAC "L", $2,990 estimated. Auveloper by S. S. White.

Dental Plaster

Defense Medical Materiel Board has requested a change in the cataloging of plaster for dental use. The terminology and the stock number will be changed in the Federal Supply System. Effective with the November Change Bulletin, plaster will be listed as "Plaster, Dental Modeling, 35 lbs.; FSN 6520-203-7235," rather than, "Plaster, Orthopedic and Dental; FSN 6510-203-7235." The four-pound can will become "Plaster, Dental Modeling, 4 lb.; FSN 6520-687-7892."

Chuck Tool Repair Suggestion

A suggestion for an expedient repair of Starflite Air Turbine handpiece chuck wrench has been received from the Fort Jackson Dental Service.

The suggestor says that when a replacement wrench is unavailable and the hexagonal end of the chuck wrench becomes rounded and no longer will function, it can be reversed in the retainer and restored to use.

The suggested method is to hold the handle of the chuck wrench in a vice grip tool and insert the hexagonal rod in a flame. When the rod becomes red hot, remove it with pliers from handle and reverse it so the undamaged end can now be used. A few drops of crown and bridge cement in the handle hole prior to reinsertion of the rod will adequately secure it, if the force fit retention is insufficient.

U.S. Army Medical R&D Command

BG Richard R. Taylor, MC, Commanding General

Progress in Hepatitis Research

Dr. Saul Krugman and his colleagues at New York University, working under an Army Medical Research and Development Command contract, have recently demonstrated that patients can be protected from infection by the Serum Hepatitis (SH) virus, using both active and passive immunization procedures.

Upon administering boiled serum known to contain SH virus to patients, Dr. Krugman has demonstrated protection from infection. He has also shown that gamma globulin prepared from the blood of a patient who had received multiple transfusions afforded patients protection from SH infection. While it is premature to talk about a serum hepatitis vaccine, Dr. Krugman's observations bring medical science closer to this objective.

Dr. Fred Leonard Receives Presidential Award

In an afternoon ceremony at the White House on 5 May 1971, President Nixon presented Dr. Fred Leonard the Presidential Award for Distinguished Federal Civilian Service. Attending were Dr. Leonard's wife, Mildred, and a select group of high-ranking government officials.

Dr. Leonard has served as Scientific Director of the Army Medical Biochemical Research Laboratory at Walter Reed Army Medical Center from 1962 to the present. He is recognized nationally and internationally as a leading authority in the fields of polymer chemistry and biomedical engineering. He has made many outstanding contributions in the development of prosthetic devices and anatomical restorations.

Dr. Leonard has also aided in the synthesis, evaluation and fabrication of plastics materials and devices for internal body prostheses, including arteries, tracheas and femoral head prostheses.

Especially noteworthy is his initiation of the development of a tissue-receptive adhesive. This is used as hemostatic agent and for non-suture closure of wounds, in place of, or adjunct to, conventional surgical sutures. The use of this adhesive on selected patients with liver and kidney injuries has saved the lives of severely wounded soldiers on the battlefields of Vietnam.

The Presidential Award consists of a gold medal and a citation, and is the pinnacle of all awards for government employees. Dr. Leonard is the fifth Army employe and the third Medical Department employe to receive this high honor since the inception of the award in 1958.

Laws of Energy Consumption in Nutrition

The U.S. Army Research Institute of Environmental Medicine (USARIEM) has a limited number of copies of the English translation *The Laws of Energy Consumption in Nutrition* by von Prof. Dr. Max Rubner, originally published in 1902. The translation and editing of this classic were accomplished through the personal efforts of

COL Robert J. T. Joy, MC, while he was a member of USARIEM in early 1968.

This work should be of particular value to research investigators or historians with an interest in nutrition, metabolism, or work physiology. Many laudatory comments were received from the recipients when it was distributed in 1968.

Institutes, organizations, and scientists desiring this document should submit a written request to the Commanding Officer, U.S. Army Research Institute of Environmental Medicine, ATTN: MEDRI-SA, Natick, Mass. 01760.

Automatic Field Lens Fabricator

Eye glasses are a fragile field commodity for the soldier, getting lost or broken and leaving him ineffective until replacement can be made.

Since one of three Army personnel wear spectacles, and approximately 40 per cent of these individuals annually require spectacle repair or replacement, a soldier's unproductive time to his unit becomes particularly significant.

To minimize individual downtime, the R&D Command began a project in 1969 designed to provide fitted prescription eyewear as far forward as combat conditions will allow. This concept, now being investigated by Life Systems Research Institute, Los Angeles, Calif., envisions a device to automatically fabricate any desired spectacle lens from optical material. Plastics are now being evaluated as a suitable lens material in view of recent progress to improve the material characteristics for use as optical lenses. Consideration is also being given to the concurrent development of easily adjustable frames.

The ultimate goal is to provide a reliable and easily maintainable system that will fabricate a pair of glasses within 10 minutes, require minimal operator training, and be transportable in a 1/4-ton truck.

Jet Injector for Veterinary Medicine

A requirement exists for equipment to rapidly and efficiently administer veterinary biologicals in large-scale vaccination programs.

The Hypodermic Injection Apparatus, Jet (FSN 6515-656-1021), "Jet Injection Gun," is being modified for such use. The jet injection gun, widely heralded as a significant contribution in mass immunization of humans, has equally great potential for use in veterinary medicine. The injector will complement the professional skills and biologicals available for combating foreign animal diseases in militarily strategic regions of the world. It would also be useful if exotic animal diseases were introduced into the North American continent.

The R&D Command, in conjunction with the U.S. Department of Agriculture and Texas A&M University, is modifying and evaluating the standard gun for veterinary use. Evaluation will be conducted in two phases:

- Present equipment will be evaluated to determine dose delivery characteristics.
- Efficacy will be evaluated by utilizing the equipment in large scale field tests.

New Military Food Hygiene Division

The Food Hygiene Division of the U.S. Army Medical Research and Nutrition Laboratory (USAMRNL), Denver, Colo., was officially opened in ceremonies on 8 March 1971, with a ribbon-cutting by COL John E. Canham, MC, Commanding Officer of the USAMRNL and COL Joshua E. Henderson, VC, chief of the new division.

Military requirements and technological developments have combined to introduce new foods, new packaging and new methods of food preparation and service for military use. The research activity at the USAMRNL was established to fulfill The Surgeon General's responsibility for assuring safe and wholesome foods throughout the military food service system. The development or application of new hygienic procedures or standards will be a major area of investigative research.

Additionally, more sophisticated methods for inspection, surveillance and evaluation of the wholesomeness status of military foods will be investigated. Reportedly, the etiology of suspected food-borne illness has been reliably determined in only a comparatively small proportion of the cases. The Division of Food Hygiene will conduct investigations and studies to define more clearly potential food-borne hazards in the military environment.

USAMRL Blood Blank Fellowship Program

The Blood Bank Fellowship, authorized under paragraph 12, Section II, DA Circular 350-65, consists of one fiscal year of intensive training at the Blood Transfusion Division, U.S. Army Medical Research Laboratory (USAMRL), Fort Knox, Ky.

The Program was begun in 1959 under the guidance of COL William H. Crosby, MC, and the late COL Joseph H. Akeroyd, MSC, at the Walter Reed Army Institute of Research.

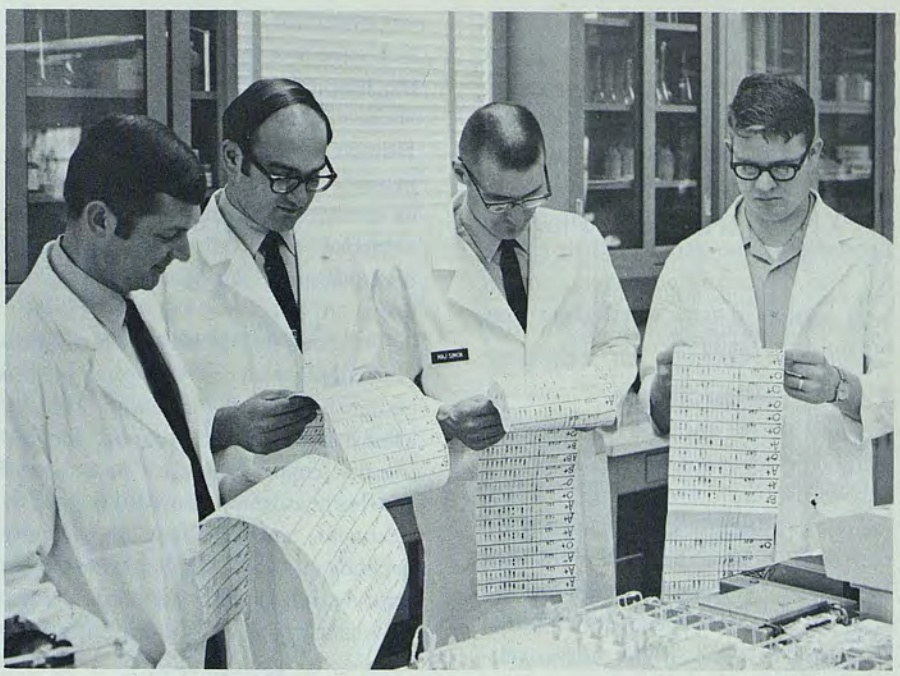
Goals of the Fellowship Program are to prepare selected career officers in the allied sciences field in all three services to (1) assume responsible positions in military blood banking, especially as administrative and technical directors of large military blood banks and transfusion services and (2) prepare for certification examination as a Blood Bank Technologist, American Society of Clinical Pathologists.

In 1958, the Fellowship Program received its recognition from the American Association of Blood Banks as a certified school for training blood bank technologists.

From 1958 through 1964, seven students were graduated from the

Walter Reed Army Institute of Research. In 1965, the Program was moved to the Blood Transfusion Division, USAMRL.

To date, 20 students have completed the Fellowship Program at Fort Knox. In 1969, the first student was sent by the Department of the Navy. With the addition of an Air Force student in 1971, the Fellowship Program at Fort Knox became a tri-service school. Since its inception in 1958, the number of students has increased from one to five per year. To date, four Fellows have been certified by the American Society of Clinical Pathologists. Six more are now taking the examination.



CURRENT FELLOWS: Studying the automated blood grouping report are *(l. to r.):* MAJ Ben Y. Linkenhoker, MSC; MAJ Theodore R. Lesser, MSC; MAJ Vern J. Simon, MSC; and LT Joe Beene, USN, MSC.

OCHAMPUS

COL Grover C. Kistler, MSC, Executive Director
Office for the Civilian Health and Medical Program of the Uniformed Services

CHAMPUS Background

Throughout the United States newspapers have recently carried stories highlighting new plans for financing and delivering medical care to everyone in the United States. Congressional members have proposed health care plans, the American Medical Association has proposed its plan called "MEDICREDIT," and the American Hospital Association has advanced its proposals in its "AMERIPLAN." Each of the plans envisions a single principle—the legal right of every person in the United States to quality medical care.

The uniformed services have for years worked on this principle, namely that its members, both active and retired, their dependents and dependents of deceased members are entitled to quality medical care. During most of their history the uniformed services provided this care exclusively in their own facilities, and it has only been in the last 15 years that care has also been made available to a significant portion of the dependent population from civilian physicians and facilities.

The evolution of civilian medical care dates back to World War II. In 1943 Congress enacted legislation providing maternity and infant care in civilian facilities for a limited population of dependents. Demobilization after the war, however, reduced the number of dependents to a level that could be reasonably accommodated in military facilities, and in 1949 care in civilian facilities was terminated. A year later, however, the onset of the Korean conflict imposed such strains on the military establishment that once again dependents were denied the quality care to which they had become accustomed.

As a result, both the uniformed services and the Congress acknowledged at this time that the availability of health care for dependents had to be expanded. Not only was it recognized that military facilities lacked the capability to provide complete care for all dependents who came to their doors, but also that many dependents simply were located in areas where there were no military facilities.

Plan Begun

To provide for the morale and well-being of those dependents unable to use uniformed service medical facilities, a health care plan was established. These benefits were first authorized by Congress with the enactment of the Dependents' Medical Care Act in 1956. This was a relatively limited program dealing almost entirely with inpatient care for spouses and children of active duty members. Outpatient care was authorized only for maternity cases and the treatment of injuries. It had severe limitations on the extent of inpatient care that could be provided for treatment of chronic conditions and emotional, mental and nervous disorders. A great deficiency in the program was that it made no provisions for care for retirees, their dependents and the dependents of deceased active duty or retired members. Nor did it provide care for the mentally retarded or the physically handicapped.

In 1966, Congress enacted the Military Medical Benefits Amendments of 1966. This legislation established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and expanded the scope of beneficiaries to include retirees, their dependents and dependents of members who die while on active duty or in a retired status. As a result, retirees and their dependents were provided geographical independence by this legislation. They were no longer required to limit "the retirement home" to an area near a uniformed service medical facility. An important stipulation was that retirees and their dependents and the dependents of deceased service members lose eligibility for CHAMPUS when they reach age 5 if they become eligible for the hospital portion (Part A) of the Social Security Medicare Program. However, if the retired member or dependent does not qualify for Part A of the Medicare Program, and obtains a notice of disallowance from the Social Security Administration, he remains eligible for CHAMPUS.

The new CHAMPUS legislation also filled many of the gaps of the earlier program by providing for an extensive outpatient program, increasing the scope of inpatient benefits and providing a comprehensive program of treatment and care for active duty dependents who are moderately to severely retarded or seriously physically handicapped.

World-Wide

The program is world-wide. Within the 50 United States, Puerto Rico, Canada and Mexico the program is administered by the Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), Denver, Colo. Administration in the European area is under the Executive Director, OCHAMPUSEUR, and elsewhere in the world it is handled by designated major oversea commanders. The portion of the program handled by the Denver office is administered much in the same manner as the Social Security Medicare Program—that is, through the use of fiscal agents in the various states for payment to hospitals, physicians and other providers of service. For hospital claims, a contract has been entered into with the Blue Cross Association and Mutual of Omaha. The Blue Cross Association is charged with the responsibility for adjudicating and paying such claims in 33 states, the District of Columbia and Puerto Rico. Mutual of Omaha administers the remaining 17 states. For services provided by physicians and other sources of care, OCHAMPUS has 45 separate contractors (Blue Shield, Mutual of Omaha, state medical societies, and other private commercial insurance carriers) who act as fiscal administrators to make adjudication and payment.

The CHAMPUS is not designed to be competitive with uniformed service medical treatment facilities. The cost-sharing provisions, first of all, tend to encourage beneficiaries to use uniformed service facilities. Retirees, their dependents and dependents of deceased members who receive outpatient care under the program must first pay a deductible and then 25 per cent of the cost. There is no deductible for inpatient care, but the 25 per cent share of the cost remains the same. Active duty dependents have to pay a similar deductible for outpatient care plus 20 per cent of the cost.

On the other hand, the charges for inpatient care for dependents of active duty personnel are similar to charges in a uniformed services facility—in a uniformed service hospital the rate is $1.75 a day, while under CHAMPUS there is a minimum charge of $25 and the rate does not become a $1.75 a day until after 14 days of hospitalization. However, dependents of active duty personnel residing with their sponsor—and therefore normally located near a uniformed services facility—must ordinarily obtain a Statement of Nonavailability before using a civilian facility for inpatient care. These statements are not normally issued unless the care required is beyond the capability of the uniformed service facility or the nearest facility is not within a reasonable distance.

Does Not Compete

Congress, in developing the CHAMPUS, originally envisioned that the program would take care of about 40 per cent of the beneficiary population. This estimate has proved to be fairly accurate, indicating that the CHAMPUS is supplementing the military care, not competing with it. The latest statistical information available to OCHAMPUS indicated that among those individuals eligible for both uniformed service and civilian medical care, the smaller number (44 per cent), are treated as inpatients in civilian medical facilities. This percentage reflects the overall picture in-

cluding all categories of beneficiaries, for hospital admissions in the United States and Puerto Rico. Mexico and Canada, also within the area of responsibility of OCHAMPUS, Denver, are excluded because there are no uniformed services facilities located in those countries.

As for outpatient care, there is no way of judging the number of beneficiaries using CHAMPUS as compared to uniformed services outpatient facilities. There is little question that thousands of the CHAMPUS beneficiaries receive outpatient services from civilian sources, but not enough to meet the required deductible.

Treatment of Handicapped

One service CHAMPUS has been able to provide dependents of active duty members not usually available through uniformed service facilities has been treatment of the handicapped. The CHAMPUS Program for the Handicapped provides a variety of specialized services, such as residential and institutional care, transportation, vocational and rehabilitative services, special education and special equipment. Care under this program requires prior approval by OCHAMPUS, Denver, OCHAMPUSEUR or the designated major overseas commander, depending on the locale where the care is to be received.

The cost-sharing formula set up in the Public Law for this portion of CHAMPUS is different from the formula for the Basic Program. The military sponsor shares in the charges on a monthly basis according to his pay grade. The monthly share for pay grades E-1 through E-5 is $25, while at the upper end of the range, an 0-10 must pay $250 per month. The most any enlisted man has to pay is $45 per month. The government then may pay up to an additional $350 per month for authorized charges. Charges in excess of this maximum must be borne by the military sponsor.

The CHAMPUS has to be considered one of the most important benefits available to the service member and his dependents, one that is scarcely appreciated by the average person until the need arises. Assured availability of medical care for dependents and retirees, be it in military or civilian facilities, is a vital element essential to morale and retention of high caliber personnel in our uniformed services. The CHAMPUS has helped greatly over the past years to ensure that, whether the beneficiary resides near or away from a uniformed service medical facility, medical care is available and that the government will share in the cost of such care received from civilian sources. Further, uniformed service members have the assurance that if they die while on active duty or after retirement their dependents will continue to receive medical care and will not be forgotten in the matter of health benefits.

It is the intent and goal of CHAMPUS to provide its beneficiaries with every possible consideration for quality health care as authorized by the law and intended by Congress. CHAMPUS was established as beneficial legislation and is being liberally interpreted to provide maximum benefits to the greatest number of beneficiaries. The importance of health and its effect on the morale of the uniformed service member, both active and retired, must never be overlooked.

VA Aid

OCHAMPUS and the Veterans Administration are cooperating in efforts aimed at aiding dependents enrolled in the Program for the Handicapped who lose eligibility for the program because of the death of their active duty sponsor. Since January, OCHAMPUS has been screening casualty reports to determine if any dependents of the casualties are enrolled in the Program for the Handicapped.

CHAMPUS officials analyze cases that are discovered to determine what benefits can be provided under the Basic Program. Then they inform the family accordingly and also notify the Veterans Administration in Washington. Through various pieces of legislation providing special Veterans Administration benefits to handicapped individuals, the Veterans Administration can pick up some of the benefits provided by CHAMPUS.

Quarterly Billings for Orthodontic Work

Under a recent change in policy relative to orthodontic billings, if the orthodonist bills an approved beneficiary under the CHAMPUS Program for the Handicapped on a quarterly basis, the total amount so billed shall be considered as having been incurred during the month in which the bill is submitted, even though the services billed for may have been provided during each of the months comprising the quarter in question.

Normally, billing on a quarterly basis is the method that is of greater financial benefit to the beneficiary, particularly when the monthly charge is less than the sponsor's cost-sharing portion. Orthodontists have been encouraged to bill CHAMPUS beneficiaries on a quarterly rather than monthly basis for care provided subsequent to the month in which the initial charge is rendered for banding the teeth.

Simultaneous Benefits

Authorized dependents of active duty personnel may now receive benefits simultaneous under both the Basic Program (outpatient-inpatient) and the Program for the Handicapped. For example, the dependent of an active duty member may be receiving authorized health care and services in an institution or facility under the Basic Program with transportation costs to and from that facility payable under the Program for the Handicapped.

In another situation, the purchase of equipment such as a wheel chair could be an authorized benefit under the Program for the Handicapped while the Basic Program could be absorbing other hospitalization costs. The sponsor or beneficiary would still be responsible for his statutory share of the costs under both programs. The only prerequisites are that the

medical condition under treatment qualifies under *both* programs and there is no duplication of benefits.

Durable Equipment Cost Relief

The cost of durable equipment purchased under the Program for the Handicapped can now be spread out over a period of months when the beneficiary continues to receive benefits from the prolonged use of such equipment. In the past, because CHAMPUS was limited to paying a maximum of $350 a month, that sum was the most the program could contribute toward the purchase of expensive equipment.

Under the current ruling, if a Sergeant (E-5) purchases a $1,200 hospital bed and this is the only charge incurred under the Program for the Handicapped, CHAMPUS can pay up to $350/month until the charges are satisfied. The cost would be broken down as follows:

MONTH	TOTAL COST	SPONSOR'S SHARE	GOVERNMENT PAYMENT	BALANCE DUE
Jan 1	$1,200	$ 25	$ 350	$850
Feb		25	350	450
Mar		25	350	75
Apr		25	50	0
Total	$1,200	$100	$1,100	

State and Local Taxes

State and local taxes applying directly to health services and supplies that are CHAMPUS benefits are now considered part of the beneficiary's medical expenses and are payable under the cost-sharing provisions of the CHAMPUS. Such taxes, i.e., sales taxes, use taxes, professional, business or occupation taxes and gross income and gross revenue taxes, will be included as part of the reasonable charges determined by the fiscal administrator or hospital contractor for all authorized services, supplies and/or equipment furnished beneficiaries. This clarification applies to both the CHAMPUS Basic Program as well as to benefits under the Program for the Handicapped.

U.S. Army Medical Field Service School

MG Kenneth D. Orr, MC, Commandant

Advanced Dental Auxiliary Course

One of the objectives of the Army Dental Corps has been to increase its capabilities in providing oral health care by expanding the utilization of dental auxiliary personnel. To accomplish this goal, a special program of instruction titled, "Advanced Dental Auxiliary Course," was started on 19 April 1971. It's being used as a pilot study to determine the feasibility of using dental auxiliary personnel in an expanded role.

Twenty dental auxiliary personnel were selected to attend this course, 10 of whom have the 91E20 MOS; the remaining 10 have the 91E30 MOS. The training period is 19 weeks for the 91E20 group, 16 weeks for the 91E30 group.

Included in this training are the application of the rubber dam; condensing, carving, and finishing amalgam, silicate and acrylic resin restorations; application and removal of periodontal dressings; and making alginate impressions. This part of the instruction constitutes Phase I of their training.

Graduates of Phase I will enter Phase II, whereby the dental auxiliary personnel will be assigned to a two-year stabilized tour at a CONUS installation.

At the completion of this pilot study, an evaluation of the effects of such expansion of the role of dental auxiliary personnel on the oral health care capabilities of the Army Dental Corps will be made.

Dental Command and Staff Course (7M-F6)

The first Dental Command and Staff Course (7M-76) was presented at MFSS from 26 April-7 May 1971, with 12 dental officers scheduled for imminent oversea assignments attending.

The course provided concentrated training in dental command and staff procedures and related administrative and management policies related to the utilization of dental resources in accomplishing the AMEDD mission. Concurrently, the Medical Department Activities (MEDDAC) and Hospital Command Orientation Course (7M-F5) was presented by MFSS.

This provided an excellent opportunity for the dental officers of the Dental Command and Staff Course to participate with the Medical Corps officers in the MEDDAC course in special seminars devoted to installation organization, MEDDAC organization and resource management and also in attending special lectures by guest speakers.

Attending were: COL Raymond H. OSTERHOLTZ, Fort Hood TX; COL Frederick A. KALRSON, Jr.; Tacoma, WA; LTC Stanley H. BRUCKHEIM, Jr., Phoenixville, PA; LTC Robert B. BURGER, Fort Huachuca, AZ; LTC

Robert M. FREENY II, Fort Devens, MASS; LTC John F. NELSON, U.S. Army Institute of Dental Research, Washington, DC; LTC Iincoln A. ROSS, Jr., Fort Campbell, KY; LTC James T. SAARI, Fort Campbell, KY.

Also attending were: LTC Francis A. SAN FILIPPO, Brooke General Hospital, Fort Sam Houston, TX; LTC Hercilio VAZQUES-TORRES, Fort Gordon, GA; LTC Dale W. HUTCHINS, U.S. Army Institute of Dental Research, Washington, DC; and LTC Erby R. OGLESBY, Leavenworth, KA.

Military Science Division

New Military Science Lesson Plans

General Subjects Branch, Military Science Division, has recently revised several lesson plans and instructor manuscripts. They are: LP/IM 44-150-401 through 44-150-406, "Drill and Command," 6 hours; LP/IM 44-150-680, "Motor March Planning," 2 hours; and LP/IM 44-150-16, "Character Guidance Program," 1 hour.

Copies of the aforementioned lesson plans and instructors' manuscripts may be obtained from the Nonresident Instruction Division, MFSS Brooke Army Medical Center, Fort Sam Houston, TX 78234.

NBC Sciences Division

Supply System Items Containing Radioactive Material

Technical Bulletin 750-237, "Identification of Radioactive Items in the Army Supply System," 12 February 1970, supersedes TB 750-237, 23 July 1968. It identifies items, other than nuclear weapons components, in the Army supply system that are known to contain, or suspected of containing, radioactive material. It is intended to assist personnel, especially those performing maintenance, storage, disposal, and radiation protection operations, in taking appropriate precautions in the presence of radioactive items.

ABC-M5A1 Radiological Fallout Area Predictor

The new expendable M5A1 radiological fallout area predictor has been distributed. A copy of TM 3-6665-277-10 is issued with each predictor. The M5A1 predictor supersedes the M5 predictor. Change 2, TM 3-210, "Fallout Prediction," covers use of the predictor in the preparation of simplified fallout predictions.

Basis of Issue of AMYL Nitrate and Atropine

Medical items used in the treatment of certain chemical agent casualties are amyl nitrite for blood agent casualties and atropine for nerve agent casualties. The basis of issue for these expendable items is contained in Supply Bulletin 8-100, September 1970.

MEDDAC and Hospital Commanders Orientation Course

Twenty senior Medical Corps officers were recently graduated from the new Medical Department Activities (MEDDAC) and Hospital Commanders Orientation Course, conducted at the MFSS. This fast-paced short course is designed to prepare selected Medical Corps officers for assignments commanders of hospitals and Medical Department activities.

In an address to the class on 3 May 1971, LTG Hal B. Jennings, Jr., The Surgeon General, crystallized the "Team Effort" concept required to provide efficient and effective delivery of health care services. The Surgeon General's remarks underscored many of the significant principles, practices, and interrelationships stressed in the course.

The course content has been organized under broad categories of Commanders' Environment, Organization, Patient Management, and Resource Management. This comprehensive course is conducted in an executive atmosphere and employs seminars, interdivisional presentations, and guest speakers and panelists from several different installations.

The interdisciplinary presentations, including a number of evening seminars and reactor panels, featured a blend of doctrinal and experiential dimensions. This was done by bringing together regularly assigned instructors at MFSS and selected officers who are occupying key command and staff positions in various MEDDAC's.

Graduates of this innovation course, all Medical Corps officers, included:

COL James D. Amos
COL Edward L. Buescher
COL Charles C. Eaves
LTC Robert H. Fike
COL Earl W. Gorby
LTC Kelly G. Gregory
COL James E. Hertzog
COL Charles W. Metz, Jr.
COL Alton B. Peyton
LTC Basil A. Pruitt, Jr.
LTC John C. Richards
COL Elliott J. Romsey
COL Adolphe J. Schoepflin
COL Albert W. Stratton
LTC Foster H. Taft, Jr.
COL Isami S. Tachima
COL Wilfred T. Tumbusch
COL Willard R. Warren
LTC William P. Winkler
COL George S. Woodard

Army-Baylor Alumni Group To Gather

The U.S. Army-Baylor University Health Care Administration Program Alumni Association will hold its annual meeting Tuesday, 24 August 1971, in the Sheraton-Chicago hotel.

As in the past, the meeting will be in conjunction with the American Hospital Association meeting, held 22-27 August 1971 in Chicago. All alumni are urged to send an updated address card to insure receipt of the annual *Alumni Newsletter.*

Send address changes to LTC Angelo J. Troisi, MSC, Secretary, U.S. Army-Baylor University Alumni Association, HCA Division, USA MFSS, BAMC, Fort Sam Houston, Texas 78234.

CONSULTANT'S CORNER

Adolescent Medicine — Now!

COL Frederick C. Biehusen, MC
Chief, Pediatric Services, Walter Reed General Hospital
Pediatric Consultant to The Surgeon General

The first adolescent clinic in the Army Medical Department was started at Letterman General Hospital in 1958 as a result of the recognized need for individualized medical care of this age group. The experience at Letterman showed that an adequate clinic could be established, prove its need, and provide a rewarding experience for pediatric residents who were assigned to the clinic as part of thier formal rotation.[1,2,3]

The adolescent, bridging as he does childhood and adult life, is perhaps the most interesting and rewarding patient with whom one can be associated. They are truly appreciative of any effort made on their behalf and more than repay the interest and time expended on them by their loyalty and the results obtained.

Characteristics and Problems of the Adolescent

Adolescence has been defined as "the period of accelerated growth in height and weight associated with the appearance of secondary sex characteristics and terminated by cessation of growth, and usually associated with emotional maturity."[4] This concise definition encompasses certain characteristics:

- Overly Concerned with Themselves
- Sensitive About Growth and Development
- Live Strenuously
- Need for Sexual Adjustment
- Readjustment of Feelings Towards Adults and Parents
- Need for Success and Praise
- Re-evaluation of Religion
- Need for Friends
- Need for Expressions of Loyalty
- Retreat from the Independence They Seek
- Retreat from Their Problems

While primarily a healthy age group, adolescents do present to physicians certain common problems noted below:

- Growth and Obesity
- Acne
- Dysemenorrhea
- Gynecomastia
- Kleinfelter's Syndrome
- School Failure
- Drug Abuse
- Ulcerative Colitis
- Psychosomatic Complaints:
  - Fatigue and Headache
  - Low Back Pain
  - Precordial Pain and Tachycardia

An understanding of these characteristics and problems is necessary before any physician can provide comprehensive care to the adolescent patient.

Role of the Adolescent Clinic

The Adolescent Clinic should provide a pleasant environment where the patient is seen by interested physicians willing to listen and not preach. The pediatrician is perhaps the obvious choice to provide primary staffing for the clinic. He is familiar with growth and development, often knows the patient over the years and has established rapport with the family. Basically there is only one requirement for the physician—his interest in the adolescent as a person. Specialty background becomes secondary if this prime prerequisite is fulfilled.

The appointment schedule of the clinic must reflect the need for adequate time per patient. An hour for an initial appointment is not too long. Since the physician must be a good listener (the patient can be preached to at home), it often takes an hour to establish the initial relationship while the patient sizes up his doctor and decides whether or not he can trust him with the problem at hand. The receptionist should be a person capable of meeting the patients on their own terms and of understanding that occasionally a patient will walk in with a problem that "cannot wait," and arrange at least some time with the

physician so evaluation and need can be determined.

The clinic staff should appreciate present modes of dress and haircuts, the language, and the importance of complete honesty in dealing with this age group. Nothing will turn a teenager off quicker than the feeling that he is "being had" or handed a line.

To foster the feeling that the adolescent is important, consultants should, whenever possible, come to the unit to see patients and not ask the patient to roam the hospital to new and often strange and depressing environments when consultation is necessary. The consultants to the clinic should include, whenever possible, a psychiatrist and a medical social worker.

Now that both Class I and Class II hospitals are beginning to develop adolescent clinics, the barrier previously imposed by the permanent change of station by the patient's sponsor should become less of a problem.[1] The adolescent will be able to move from one adolescent clinic to another and receive the same interested medical care.

Physical Facilities and Staff

Success in relationships with the adolescent depends in great part on creating an atmosphere where he feels wanted and is treated as an individual. Therefore, the Adolescent Clinic must be an entity unto itself. It must not be a corner of the pediatric clinic with pediatric-sized furniture and magazines and books, with small examining tables or nursery rhymes painted on the walls. Rather, it should be an area that the adolescent finds attractive and comfortable. It need not be elaborate, or even require large expenditure of funds, but it should be special. If it is necessary to share a clinic area, it should be an adult clinic where some special provision may be made for the adolescent.

"There is only one requirement for the physician—his interest in the adolescent as a person."

The basic requirement is for an outpatient unit but, if local space requirements permit, a small four- or five-bed inpatient unit may be provided where the clinic staff can admit their patients, follow them and maintain the appropriate relationships. Otherwise, officers' and womens' wards may be used for the occasional patient admitted and arrangements made for the clinic staff to follow them while in hospital.

Clinic as Part of the Pediatric Residency

The civilian community has long realized that the adolescent is a direct extension of the pediatric patient and that inclusion of adolescent experience is a basic and important part of the up to date pediatric residency. Residency review committees are stressing the importance of this philosophy and urging adolescent medicine experience in all approved programs. Military medicine is in an extremely advantageous position to improve its program as well as begin co-operative clinical studies on the adolescent, his family, and contemporary problems, such as drug abuse. The fact that residents are enthusiastic about the adolescent is pointed up by the increasing numbers of graduates of Army Pediatric programs interested in Adolescent Medicine.

Summary

It is becoming increasingly evident that pediatric training programs must include adequate experience with adolescent medicine to receive continued approval. It is also evident that pediatric trainees in Army programs are interested actively in obtaining further postgradaute training in this exciting area of medicine. Existing physical facilities can be adapted to use by the adolescent at little or no expense and present staffing levels may be utilized to provide outstanding medical care for this rewarding age group.

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Tips and Treatment

This is a new section of the Consultant's Corner, to be contained in each forthcoming issue. Its purpose is to keep the Army physician abreast of hazards associated with drugs and treatment that have not been publicized to any extent. The section on New Treatments is devoted to the dissemination of information pertaining to new methods of diagnosis and treatment and to encourage the reader to search for further information in his area of interest. These items are not meant to stop or restrict use of drugs listed, but to bring to the fore complications which have been reported. Publication does not, in any way, constitute indorsement or condemnation, of any product or technique, unless specifically stated.

Drug Tips and Cautions

Diphenylhydantoin

Previous reports have discussed the serious side effects associated with diphenylhydantoin (Dilantin) therapy. Gingical hyperplasia, pruritus and erythema, giant urticaria, depression, hypotension, temporary blood dyscrasias, ECG abnormalities, cardias arrhythmias (including cardiac arrest following intravenous administration) and diffuse lymphadenopathy are included in the side effects.

A review of the literature prompted by a recent instance in which a presumably benign Dilantin associated lymphadenopathy recurred in the form of a fatal malignant lymphoma revealed that a similar experience involving a group of patients was reported several years ago.

The author of a recent report issues the following warning:

> Most serious is the widespread belief in the benignity of the process. There is now ample precedent for the recurrence of a fatal lymphoma despite initial regression of adenopathy upon withdrawal of the hydantoin drug.

Diphenylhydantoin has been found, however, to detoxify DDT, DDE and dieldrin by reducing tissue residues.

Oxytocin

At least 16 cases of oxytocin-induced water intoxication have been reported in the literature; clinical manifestations included convulsions in 13. In the most recent case reported, a 25-year-old primigravida experienced a grand mal seizure 24 hours after the administration of 200 units of oxytocin in 4,000 cc glucose/water to control severe late postpartum hemorrhage; she recovered following substitution of hypertonic saline for glucose infusion.

The authors point out that "patients receiving high-concentration oxytocin solutions, particularly if these are administered for prolonged periods, should have their sodium and chloride levels monitored frequently (every six hours) as the only absolute method for detecting water overload."

Iatrogenic Meningitis

After the fifteenth case of post-lumbar-puncture meningitis over a 30-month period at Wilford Hall USAF Medical Center, San Antonio, reusable spinal tap trays were replaced with disposable units; the incidence of chemical meningitis since the changeover nearly five years ago is zero.

Ketamine Hydrochloride

Despite its neophyte status, ketamine is already attracting attention in ways apparently unanticipated by the FDA when the product was approved as a general anesthetic agent 10 months ago.

That the "paradoxic' side effects publicized with the drug's introduction are not necessarily benign is apparent from recent experience reported from Ireland. In a study involving over 450 administrations in Belfast hospitals, clinically significant elevated pressures, increased heart rate, and emergence delirium were reported in approximately 75 per cent of ketamine-anesthetized patients. Twenty-millimeter or greater increases in systolic pressure occurred in 50 per cent who received induction doses of 2 mg/kg, and in 70 per cent of those given higher doses. Emergence delirium occurred in one third; half of these required therapy (diazepam).

Limited experience with the new agent suggests the incidence of untoward effects can be reduced by employing specific preanesthesia regimens.

Developed by Parke-Davis, ketamine hydrochloride is marketed by Parke-Davis and Bristol Laboratories under the trade name Ketalar.

Aspirin

The untoward side effects of this most widely employed of all drugs, both solo and in combination, have been pointed out frequently in these pages; recently reported experimental and clinical evidence emphasizes the importance of maintaining a healthy respect for the toxic potential of this ubiquitous analgesic. In recent animal experiments conducted by research personnel at the Merck Institute for Therapeutic Research, aspirin was found to antagonize the anti-inflammatory effects of indomethacin, flufenamic acid, and phenylbutazone; mechanism of the antagonism is unknown. Conceivably, the anti-inflammatory properties of aspirin and another product may nullify each other while their toxic effects are synergistic.

Investigators at the University of Pittsburgh report "prolonged prothrombin times and hemorrhagic phenomena" in aspirin-treated patients on warfarin therapy; this phenomenon has been reported previously. Investigation revealed no other cause for bleeding and these patients responded promptly to vitamin K therapy. Mech-

anism of the interaction is thought to be identical to phenylbutazone potentiation of the warfarin effect: competition for a common binding site on serum albumin. At both 0 and 37 C, warfarin is more tightly bound, but significant displacement of warfarin occurs at higher concentrations of salicylate; this effectively increases the concentration of "free" warfarin in the serum. Salicylate levels up to 6.44 X 10^{-4} have been recorded following the ingestion of as little as 1 gm of aspirin; free warfarin increases up to 20 per cent may result from concentrations of this magnitude.

Diazinon

Although generally innocuous to children and adults in commonly employed concentrations, phosphate insecticides and other poisonous sprays may precipitate severe toxicity in infants, particularly smaller infants subjected to prolonged exposure due to their immobility.

Three-week-old twins were admitted to the hospital with respiratory distress increasingly apparent over the preceeding 12 hours. One was cyanotic and both demonstrated acute respiratory distress characterized by rapid, shallow excursions, profuse nasal and bronchial secretions, and pinpoint pupils. Pseudocholinesterase activity in the sicker twin was 168 millimoles acetylcholine/hr (one standard deviation below the mean), 48 hours after admission. Treatment was symptomatic plus atropine and pralidoxine in the more severe case. The response was satisfactory and both patients were discharged essentially asymptomatic after five days.

Both the manifestations and response to treatment suggested phosphate poisoning. Investigation revealed that the other half of the two-family house in which the infants lived had been sprayed for control of cockroaches with one per cent Diazinon, the odor of which was apparent for several days. The phosphate-base poison is readily absorbed through the skin and mucous mmebranes. In one other reported instance, three children experienced near-fatal poisoning after floors and bedclothing were sprayed with an oil formulation of Diazinon. Clinical manifestations in addition to those described above include bradycardia, diarrhea, coma and convulsion.

New Drugs and Treatment

New Vaccine

Administration of a new vaccine against Mycoplasma pneumoniae has resulted in an increase in antibody titers in all 45 volunteers studied after immunization. Of those who already showed antibody levels, 82 per cent registered an increase in antibody after vaccination. The new material was cultured from a strain isolated from a 5-year-old child, grown in bovine serum, and inactivated with formalin.

According to the Texas investigator responsible for the study, the next stop will be to challenge these volunteers. If the challenge results are successful, field trials probably will be conducted at military bases, where the disease is a serious problem.

Hansen's Help

Use of thalidomide appears to be a major advance in the management of erythema nodosum leprosum. While its mechanism of action is unknown, thalidomide significantly alleviates the fever and skin lesions of this condition. Despite its teratogenic effect, it is considered less toxic than the corticosteroids.

Mini-Coner

The mini-coner facilitates taking cervical scrape biopsy specimens in the office. The instrument resembles a double-headed arrow. With it the physician can obtain a 360-degree superficial scrape specimen of the squamocolumnar junction. Specimens are collected in the groove of the device by applying pressure and rotating the instrument in the cervical os. The head of the mini-coner, with the specimen inside, is broken off, placed in formalin, and sent to the pathologist. The procedure, simple and painless, can be performed without anesthesia or significant bleeding.

Although the mini-coner biopsy does not take the place of the Pap smear or cold cone in diagnosis of cervical cancer, its use may eliminate unnecessary hospitalization for cone biopsy; sufficient tissue can be obtained for an elective screening procedure.

Methadone Substitute

A British research team has discovered that a combination of diphenoxylate and chlormethiazole helps to wean addicts without the danger of addiction to the treatment itself. Diphenoxylate, administered in doses of 2.5 mg, g. 4 h., countered the cramps and pain of "cold turkey." Chlormethiazole, two to four 0.5 mg tablets (sufficient to achieve deep sedation), is employed to control the addict's anxiety. Of over 100 addicts so treated, most were weaned off narcotics in five or six days without any autonomic withdrawal symptoms. The only significant side effect noted was a mild, transient drop in blood pressure.

Transplant Antigens

Two scientists report that they have devised a method to "trick" the body of a recipient into accepting a donor organ. The process consists of the following: while blood cells are drawn from a prospective donor and preserved in tissue culture in the laboratory; the antigens in the donor cells are then extracted and injected into the recipient, thereby desensitizing him and tricking his body into accepting an organ from the donor. The investigators plan to initiate clinical trials within a year.

FOOTNOTE:

Our appreciation to Paul G. H. Wolber, M.D., Harper and Row, Publishers, Inc., Medical Department, for his cooperation and aid.

SPECIAL ARTICLES

The Philosophy of MEDDAC

LTG Hal B. Jennings, Jr., MC
The Surgeon General, U.S. Army

General Jennings gave the following talk to participants of The Surgeon General's Joint Conference for Theater and Army Surgeons, Center Commanders and Hospital Commanders, held in Washington, D.C., 13-16 April 1971. It is published for information and guidance of all Army Medical Department members.

MEDDAC (Medical Department Activities Command) is just a new term applied to a relatively old concept of delivering health care. It centralizes the resources and fixes the responsibility for this health care delivery. The new terminology should stress the military aspect of *command* by which this fixing of responsibility is inherent. In the past this was not as evident when the terms "Area Medical Service" or "Medical Service Activities" were used. Now in WORSAMS we are advocating the organization of the many separate Medical Commands into a centrally coordinated and controlled Medical Activity Command designed to give the optimum in efficient service.

To give total health care services requires a total AMEDD's Team Effort. The total AMEDD's Medical Team concept MUST become a reality. Whether we call it Area Medical Service, MEDDAC, WORSAMS, or whatever, the concept or philosophy is still the same. It is the all-out attempt by a team of fully cooperative and dedicated health services personnel all trying to give the optimum, most efficient, and most economical total health care services to the community authorized these services.

This policy is the rock or foundation upon which the Army Medical Department is built. The AMEDD team effort MUST become a fact and not merely a slogan. This policy has recently been reviewed and unanimously reaffirmed by The Surgeon General's Policy Council. This Council consists of all six Medical Department Corps Chiefs. They reaffirmed that there can be no splintering, no fragmentation, of the AMEDD's Medical Team. They reaffirm that we could not exist separately.

Oral and Total Health

Certain laws and regulations fragment or treat separately the services allowed to the oral health of an individual. This is wrong! How can you separate the oral health from the total health of a person? They are interdependent. You cannot separate the oral cavity from the rest of the body! Thus we are bending every effort to be allowed, within AMEDD resources, to give dental care to all of our population responsibility on the same basis that we give medical and surgical health care. The body cannot be fragmented. All of its parts are interdependent and interrelated. The health of one part affects the health of another part. Thus it is with the Medical Team and the health care it renders—one part affects another. We must work together and coordinate our efforts as well as the services we give.

It is my contention that we have become much too hospital-oriented in the past. Now, we must revise our thinking and orientation. The hospital per se is an important cog in the wheel of total health care but not the sine qua non. Many more people are treated as outpatients than as inpatients, even in war times. Those patients actually hospitalized get a personalized and individual attention and the treatment is the best. We rarely get a complaint from our inpatient customers. We must become more outpatient oriented, not at the expense of inpatient care, but by redistributing our attention and resources, now that the inpatient care is going so well. Thus it is with MEDDAC—we must constantly and consciously think about the revision and redistribution of responsibilities and how we can coordinate these in their priority settings in tune with the changing times.

I see a complete parallelism, that

should be self-evident, between our Medical Department's primary three Doctorates—Doctor of Medicine, Doctor of Dentistry, Doctor of Veterinary Medicine. If we set aside the inpatient part of patient care from these three—each has a clinic or treatment responsibility and each has a preventative responsibility.

AR 40-4 prescribes that Dental Service and Veterinary Service are a part of the Health Delivery System run by the Army Medical Department. Both Dental and Veterinary personnel, equipment and facilities are a part of the MEDDAC's TDA and are separately identified in appropriate paragraphs thereof. The Dental and Veterinary Deputies of Headquarters MEDDAC command their respective elements of the MEDDAC's TDA. They prepare their respective parts of the MEDDAC budget and programs. Per change #2, paragraphs 2-28 of AR 40-4, they are responsible (whether they do it or not) for "advising the installation commander on their part of the health of the command." But, for the team effort and common AMEDD goal, the MEDDAC Commanding Officer should also be made aware of all dental and veterinary actions and problems. In no place have the Deputies of MEDDAC been prohibited from access to their installation commander. It is exactly like my relation to DCSPER. I have direct access to Secretary Resor and General Westmoreland, but I also keep DCSPER informed so that all actions and problems can be coordinated at his level. I do this with DCSPER even if the Chief of Staff should call me in directly or should I ever go to him directly. Information copies or memos are very nice to use to keep the other party, who is involved or committed, informed.

Two Hats

When one has two responsibilities or wears two hats, he must always stop and think with each action as to which hat he is wearing. This is mandatory for each one of us. The comptroller, for example, although housed most often in the hospital, wears the MEDDAC Comptroller hat and also must act for the Commanding Officer of the Hospital, the CO, Dental Activity; and CO, Veterinary Activity. The personnel officer too can be considered wearing multiple hats within the MEDDAC and must play fair and impartial, being sure of which hat he is wearing for each action. What is essential, is the recognition by each person that the team effort is a two-way street. One can't just sit back and secretly or clandestinely complain that he isn't asked in or isn't included in. Each must make a conscious, sincere, interested effort to apply these principles in the everyday practice of the MEDDAC concept. Like the student violinist who has the desire to become a virtuoso but also knows that it won't come easy—and finally—by conscious daily work on the techniques and principles, makes the squeaky fiddle become a mellow violin —I have hopes that our team will learn to play together with few, if any, squeaks. To this end we all must be dedicated!

I say we cannot look to civilian health services for guidance. They are fragmented and don't have the central direction and coordination that is possible in the Army Medical Department. In civilian health fields the Medical, Dental and Veterinary schools are separated but have many common subjects and requirements. The AMA and ADA are separate and never the twain shall meet. I say, don't look back at these examples and schisms. Let's look forward and strive to develop new concepts and methods of health service and lead the way, as the Army Medical Department has done so often in the past. It is difficult to get these concepts across as a way of life to all AMEDD people. Our people come to us from civilian life where the Dental and Veterinary activities are not totally integrated as a part of the health care team. Thus, it is not unusual for each to go his merry, independent way, excluding the other team members (without prejudice) from their own daily routine official and social activities. This is not insurmountable. It only means that we must work twice as hard to overcome these indoctrinations and oversights. All parties must consciously think, educate and attempt to change these negative or no-attitudes, into positive, working, total health team attitudes.

Leadership Concept

Now may I propound a bit on my theory of command, or team leadership, within the Army Medical Department. Every team has its leader or one who calls the signals, as with a football team. As our AR's are written at present, the Medical Corps is the head of the health care team in the Army. The Surgeon General is designated to be a doctor of medicine. This designated leadership concept has been carried down through all levels of the Army Medical Service without much change. Back when the Army Medical Services were also fragmented, each Post Commander's Surgeon, Dental Surgeon and Veterinary Officer were completely independent of one another and each of these three received only a dribble of money, personnel and equipment from the staff of the post who had little real knowledge of health care. Often, those staff officers, or commanders, received and reserved the best health care for themselves and theirs, and the troops got the dregs, much like the distribution of health care to the rich and poor of the civilian economy of those days.

During the last 10 to 15 years, the Army Medical Department began to integrate the various parts of total health care beginning with Area Medical Service in Europe. The "health team" has continued to evolve and hopefully will culminate in the approval of the WORSAMS study recommendations. Now, much like the struggle for command jobs in the Army "line," our AMEDD officers have the desire for a chance to command. MEDDAC has extended this opportunity a great deal. At present, the team leader or Commander of a MEDDAC, having live patients to treat, must be a Medical Corps officer. I personally see no objection to any of

our Medical Department officers, if qualified, commanding any medical unit or Headquarters when in a training status or having no direct live human patient treatment responsibilities. The only current restrictions on this propounded policy stem from our paucity of professional people available to give direct patient care. When we have scrutinized every TO&E or TD slot and eliminated the absolute need for the services and/or qualifications of an MC, DC or VC, and fully utilized that professional person in a required skill slot, and still have an excess above that needed for direct patient care—then, and only then, can we afford the luxury of this latter elective command experience.

In summary, may I point to our experiences with the Medical Command, 44th Medical Brigade, in Vietnam. Here the MEDDAC, Medical Team, WORSAMS principles, or what you will, worked with the highest efficiency and cooperation that we have yet experienced. Finally, when the Brigade Dental Surgeon and Brigade Veterinary Officer were double-hatted and both commanded their "stovepipe commands" and also served as staff members and/or deputies of the Brigade Headquarters—then we saw the true MEDDAC working during wartime. If we can make it work in war, I'm positive we can make it work in peace. To this end I am dedicated. My pronouncements on this as The Surgeon General will be frequent, loud and clear. I shall have no tolerance for petty, self-pity grievances and looking back on the old days. Our policy and goal is total coordinated effort by our medical team toward giving optimum total health care to our population responsibility and finding our real reward in the job satisfaction of giving this service.

This is my philosophy of MEDDAC!

Hospitalization & Evacuation

Third Quarter, FY 1971

From the Operations Division, Directorate of Plans, Supply and Operations

The third quarter FY 1971, as in previous quarters, reflected a decrease in operating beds worldwide in Army hospitals. At the end of the quarter the total of 25,829 operating hospital beds worldwide compared to 27,000 at the beginning of FY 71. This continuing decrease of operating beds in our hospitals is in concert with the decreased combat operation in Southeast Asia and corresponding decrease in patient loads.

The percentage of occupied beds in Southeast Asia reflects an increase over the previous quarter and this is attributed to the continued reduction of operating beds in the Republic of Vietnam (RVN) and the sharp decrease in occupied beds during the Christmas holiday period in the second quarter of the Fiscal Year.

The U.S. Army Hospital, Camp Zama (500 operating beds), has successfully handled the local patient load and the patient flow from RVN since the closing of the 249th General Hospital in early January. At the end of the quarter 69 per cent of the 500 operating beds were occupied. During the quarter there were some 3,800 patients regulated from RVN with 1,800 being regulated direct to CONUS and the remainder to Japan and other offshore hospitals.

AVERAGE BEDS OCCUPIED PER WEEK UNITED STATES ARMY HOSPITALS, SECOND QUARTER FY 1971 AND THIRD QUARTER FY 1971

Hospitals	*October-December 1970*	*January-March 1971*
CONUS		
CL II	4781	5610
CL I		
(CONARC)	6575	7014
(USMA)*	62	75
TOTAL CONUS	11418	12699
EUROPE		
(Germany)	1342	1295
(Belgium)	24	27
(Italy)	21	27
TOTAL EUROPE	1387	1349
ASMARA	18	19
ALASKA	63	75
PACIFIC		
(Hawaii)	569	557
(Japan)	250	329
(Korea)	281	257
(Okinawa)	344	328
(Thailand)	51	49
(Vietnam)**	1629	1428
TOTAL PACIFIC	3124	2948
TOTAL WORLDWIDE	16010	17090

*USMA assigned under DCSPER
**Excludes 6th Convalescent Center

Army Medical Department Chiefs

Technical Liaison Office
Office of The Surgeon General

Editor's Note: This is the fifth in a continuing series on The Surgeons General of the U.S. Army.

For many years after the Civil War the only limit on the Surgeon General's tenure of office was mandatory retirement for age. However, in the decade following Surgeon General Barnes' 18-year tour, five physicians held this title.

XIII
CHARLES HENRY CRANE
19 Jul 1825 - 10 Oct 1883

Colonel Crane had served as Assistant to Surgeon General Barnes during his full tour, so his appointment to the top post was a natural outcome of Barnes' retirement.


CHARLES H. CRANE
1882 - 1883

On 3 July 1882, Crane was appointed Surgeon General and promoted to brigadier general. The new title demanded little change in duty. He continued to manifest patient and earnest attention to the affairs of his Department. Unfortunately, he developed a malignant tumor at the base of his tongue, and died suddenly of a massive hemorrhage on 10 Oct 1883.

XIV—ROBERT MURRAY
6 Aug 1822 - 1 Jan 1913

There were many bids for the position of Surgeon General following the unexpected death of General Crane. President Arthur saw fit to advance the senior medical officer, Colonel Robert Murray, to brigadier general rank and to the position Surgeon General on 23 Nov 1883.


ROBERT MURRAY
1883 - 1886

Murray's administration was a conservative and harmonious one. His annual report for 1884 was the first to mention the use of antiseptic techniques in surgery that were being tried out in U.S. Army hospitals while Lister, the father of antiseptic surgery, was still facing ridicule in England.

General Murray retired on his 64th birthday, 6 Aug 1886.

XV—JOHN MOORE
16 Aug 1826 - 18 Mar 1907

Although General Murray's retirement must have been anticipated, President Cleveland waited until 18 Nov 1886 to announce the advancement of Lieutenant Colonel John Moore to brigadier general as the 15th Surgeon General.


JOHN MOORE
1886 - 1890

Moore's administration was progressive. The Act organizing the Hospital Corps became law. This was the first time enlisted men were given full-time assignments with the Medical Department. First Aid instructions for Army troops were initiated.

General Moore was popular personally with both military and civilian doctors, and his tour was marked by good will and efficient management.

He retired on his 64th bitrhday, 16 Aug 1890.

XVI
JEDEDIAH HYDE BAXTER
11 Mar 1837 - Dec 4 1890

The unusual and outstanding qualifications of Colonel Jedediah Hyde Baxter, who held graduate degrees in both medicine and law, were considered when each of the three preceding Surgeons General were appointed. Finally on the retirement of General Moore, President Harrison promoted Baxter and appointed him Surgeon General on 16 Aug 1890.


JEDEDIAH H. BAXTER
1890

General Baxter was full of plans for the Medical Department to be worked out in the seven years remaining before compulsory retirement, but on 4 Dec 1890 he developed an insidious uremic toxemia, and died almost without warning.

XVII
CHARLES SUTHERLAND
29 May 1829 - 10 May 1895

Following Surgeon General Baxter's sudden death, President Harrison promoted the senior colonel in the Medical Corps and named him Surgeon General. Charles Sutherland took office on 23 Dec 1890.


CHARLES SUTHERLAND
1890 - 1893

His administration was as progressive as the conservative temper of his day would permit. He concentrated on developing the Hospital Corps, and stoutly supported CPT John Van Rensselaer Hoff, who organized the first company of instruction for the enlisted hospital corpsman at Fort Riley. Hoff's theory was that the medical soldier, to survive in the field, required as much training, including drill, as any other soldier.

General Sutherland was mandatorily retired when he reached his 64th birthday on 29 May 1893.

Iran

A study of its medical evacuation system

MAJ Ruben F. Fechner, Jr., MSC
Directorate of Plans, Supply and Operations

Early this year the Advanced Research Projects Agency (ARPA), part of the Office of the Secretary of Defense, submitted a request to The Surgeon General for an officer to assist with a 60-day medical evacuation study in Iran. According to request, the study would involve reviewing Imperial Iranian Ground Force operations, estimating medical workload, determining adequacy of TOEs for unit and division level medical support, surveying expansion capability of hospitals, developing a medical evacuation system, and recommending additional resources required for an evacuation system. Also needed was a five-year plan to acquire needed resources and to implement the system.

Agencies involved in the study, in addition to ARPA and the Office of The Surgeon General, were: the Research Triangle Institute (RTI), contracted by ARPA to accomplish the study; U.S. Army Mission to the Imperial Iranian Armed Forces (ARMISH), Military Assistance and Advisory Group (MAAG), or ARMISH-MAAG; and the Imperial Iranian Ground Forces (IIGF). Two major elements of the IIGF were involved: Combat Research and Evaluation Center (CREC) and the Medical Department, or their Surgeon General.

The project was first conceived as a one-year project with RTI guiding CREC in the development and prosecution of the study. However, when the RTI and OTSG representatives arrived in Iran, it was decided that the study would be completed during the two-month TDY period.

First step of the project was to develop objectives or milestones and task various agencies for assistance to accomplish the project within the time limit. Next, a scenario was developed upon which to base the workload or estimate casualties. Workloads were computed for the evacuation system and a sample mobilization survey was made of several civilian and military facilities. An evacuation system concept was developed that included three levels of medical support, medical regulating and command and control. Finally, a force development recommendation was made to provide the resources for the system and a five-year plan developed.

TEHRAN HOSPITAL: Leyla Pahlavi Hospital is the most modern Imperial Iranian Ground Force Hospital in Tehran. A new military hospital, the 250-bed facility is devoted to dependent care and is commanded by a Medical Corps brigadier general. The hospital, less than two years old, has a staff of 500 and modern equipment including a cranial X-ray machine and other 1,000 and 500-m.a. units.

The scenario selected was an offensive situation. Conventional war was selected instead of unconventional war, and attack was selected instead of defense to produce the highest medical workload. If the high workload experience from an attack could be supported, the lesser workload from defense could also be accommodated. Because of political reasons the operation overlay was reduced to a line-drawing and the situation was described as a counterattack to eject an aggressor.

The casualty workload was based on the scenario, the type of operation, and the type of organization (the Iranians have both mechanized units, armored units, and infantry units and slightly different factors were used for each of these). The type and number of casualties were computed (KIA, WIA, DNBI).

To arrive at the factors which were used, several sources were considered. References included FM 101-10-1, FM 8-55, and articles prepared by Mr. Frank Reister (OTSG) on the Korean War. Casualties and medical workload were computed for each divisional-size element for each of the 10 days of the operation. In the forward area an estimated 2,000 mobile hospital beds would be required to relieve the divisions of their patients. For mobile beds, the combat support hospital concept was proposed. Fourteen combat support hospitals would satisfy mobile bed requirements, it was estimated. From the mobile hospital, patients would be evacuated to fixed hospitals, both in the corps area and in the rear

of the Corps area (IIGF military hospitals and civilian hospitals).

The peak workload in the interior region was estimated to be approximately 7,500 beds, about three-fourths of which could be accommodated by the Army; the remaining patients would have to be cared for by civilian facilities. The medical resources in-country appear to be adequate to support combat operations.

Iran has approximately 8,000 doctors, of whom 1,000 are in the Army, and 500 hospitals (36,000 beds). Twenty-six of these hospitals (2,700 beds) are part of the Army.

The evacuation system concept which was developed included three levels of medical service: unit, division, and army. The unit and division levels are exactly like the U.S. system. At the Army level, a mobile hospital was used in the rear of the division area and fixed hospitals were used for the remainder of the system. The medical support in the Corps and Interior Area was retained as a single level so that The Surgeon General could exercise command and control of these medical resources.

For each level of medical service, it was recommended that the senior surgeon be both the medical commander and the command surgeon. The IIGF is being reorganized under a logistical command concept, which places the Surgeon General and his personnel in a medical command, subordinate to the logistics command. The medical units would be subordinate to support brigades operating in the Corps areas. The rationale (presented to the U.S. Army in Vietnam in 1967 to effect the release of the 44th Medical Brigade from a similar situation) was presented and a proposed medical command organization was discussed with the IIGF personnel. It was pointed out that to make the evacuation system function, medical command and control must be capable of integrating the system and accomplishing medical regulating activities.

Final recommendations to the Imperial Iranian Ground Forces included the following: proposed adoption of the medical evacuation system concept; establishment of a medical regulating system; provisions for adequate medical command and control; continuing development of medical service companies (unit includes two ambulance platoons and one clearing platoon); development of mobile hospitals (combat support hospital); determining requirements for other contingencies using the methodology developed in the study; and annual reevaluation of the system as resources and conditions change.

The Chief of Staff of the Imperial Iranian Ground Force approved these recommendations in general and directed his staff to prepare a briefing for the Joint Staff and then to prepare charts to brief the ruler of their country, The Shahanshah.

New AFIP Medical Museum

From the Armed Forces Institute of Pathology

The Medical Museum of the Armed Forces Institute of Pathology was reopened 21 May in a new building adjoining the main AFIP building on the grounds of Walter Reed Army Medical Center.

LTC Hal B. Jennings, The Surgeon General, addressed the crowd at the outdoor ceremony and received the museum key from CPT Bruce H. Smith, AFIP Director.

First opened in 1862, the museum became a popular attraction after the Civil War. It was moved to Ford's Theatre in Washington after Lincoln's assassination, and later was housed in the AFIP Annex in downtown Washington.

The public museum has four exhibit halls: the Hammond Hall of Pathology, the Brinton Hall of History, the Billings Hall of Instruments and the Silliphant Hall of Current Events. The Billings Hall includes a model of a modern histology laboratory, and the Brinton Hall contains some early contributions including the bullet that killed President Lincoln.

The mueum also contains the Center for Advanced Study in Pathology, a 1-room area where pathologists will study the institute's rare medical specimens. Also included is a 19th Century conference room and historical archives.

PICTORIAL FEATURE

Concerned Care

Immed. Below: Care and concern often extend outside the hospital. A nurse bids goodbye to a new mother, father and baby. *Below Right:* COL Robert E. Neimes, MC, commanding officer of DeWitt, and an Army nurse hold a Concerned Care poster to place command emphasis on the program.

Concerned care is alive and well at U.S. DeWitt Army Hospital, Fort Belvoir, VA.

Initiated just over one year ago, the hospital's program of providing concerned care to its patients has been immensely successful. The program, designed and implemented by COL Robert E. Neimes, hospital commander and COL Edward Strobel, executive officer, was an attempt to promote an attitude of empathy and concern for patients. "It was," says Colonel Neimes, "important to sensitize the people who were in direct contact with the patient to become aware of the personality changes in patients and give them the concerned assistance they needed."

DeWitt, like many hospitals, found that an influx of patients to the hospital resulted in a stretching of scarse medical resources. The staff's attitude toward concern for the patient began to suffer as the workload increased. Recognizing the potential problems, DeWitt concentrated its efforts on an intensive program aimed at caring for the emotional needs of the patient.

One of the most significant aspects of the concerned care program was a series of sensitivity courses held for hospital personnel. The courses sought to train the hospital staff in the understanding of human behavior, the behavior of patients, and the establishment of good interpersonal relations with patients.

The training sessions, purposely kept small to facilitate discussions, were attended by a heterogeneous cross-section of the staff. Personnel heard lectures and hypothetical case presentations from Social Work Services officers and officers from the Medical Service Corps.

Right: Care of one small child often requires the collective efforts of many. *Below Right:* At the triage desk, sensitized, interested personnel provide concerned care.

Employes were told that patients upon entering a hospital for the first time often feel apprehension, fear, and confusion. In a hospital concerned with the emotional as well as the medical needs of its patients, the apprehension and fear should be soothed upon contact with the hospital staff. A good staff must be cognizant of the patient's emotional needs.

DeWitt's concerned care program also dealt with publicity and incentives. Good programs need extensive internal and external exposure. Concerned Care got just that. Information concerning the concepts and objectives of the program were disseminated through various written publications. The post and hospital's daily bulletins were used as a tool along with command letters to the hospital staff and feature articles appearing in the post and community newspapers.

Posters depicting concerned care were displayed throughout the hospital and on post. Humorous and animated drawings also appeared in publications publicizing the progress.

As an incentive, a Concerned Care Employe-of-the-Month award was initiated. This award, voted by the patients, was presented to the employe who best exemplified the ideals inherent in concerned care.

Authorities at DeWitt have adopted the philosophy that concerned care is an attitude applicable not only to patients, but also to relatives and other visitors, and toward other hospital workers at all grades and ranks. If those in direct contact with patients and visitors are not manifesting concerned care, it is likely that others in the hospital hierarchy are not manifesting concerned care about those caring for patients. We must have concern for the other's self-respect and the other's adult or maturing healthy needs.

Relations with visitors, anxious friends and relatives of patients should be conducted in a friendly, considerate manner, always bearing in mind that indifference, rudeness, stupidity, and bureaucratic dogmatism breeds anger, contempt and ultimately, loss of confidence in the hospital.

It was with this in mind that the Concerned Care Program was initiated at DeWitt and it is with this in mind that the program continues today.

The only cost of the program is in terms of a little extra time, energy, and dedication expended by the employes. There is virtually no monetary outlay.

More than a slogan, DeWitt's concerned care is paying big dividends in enhancing the nursing environment of patients and providing a more favorable hospital image in the eyes of the community.

BG Anna Mae Hays:
First Lady General Retires

Chief, Army Nurse Corps, 1 Sep 1967 - 31 Aug 1971