
ARMY NURSE CORPS NEWSLETTER

“Ready, Caring, and Proud”

Volume 05 Issue 4

February 2004



Chief's Message



COL Gustke and I want to take this opportunity to congratulate each and every Army Nurse as we celebrate the 103rd Anniversary of the Army Nurse Corps. This has been a truly historic year and we are extremely proud of the tremendous contributions that Army Nurses make each and every day, both in support of the Global War on Terrorism, and at the same time providing quality care to our soldiers and their families in our peacetime health care role. We trust that you will all have the opportunity to reflect on this auspicious occasion and realize that you are an integral part of our tremendous Army Nurse Corps History.

It was my privilege and honor to begin the New Year by traveling to Europe and witnessing firsthand the superb work that Army Nurses are doing in our very busy medical facilities in Germany. I was extremely impressed with the phenomenal way our Army Nurse Corps team is providing patient care at Task Force Med Eagle in Bosnia. This Army Reserve team was made up of 8 different units from 22 different states and the camaraderie and solidarity among the staff was extraordinary. I commend both the outstanding leaders and the great soldiers of this task force for building this team while facing their unique challenges in an environment far from home.

The staff members at Heidelberg's MEDDAC are also setting the example by providing top quality patient care while supporting the diverse European healthcare mission. The incredibly dedicated leaders and soldiers at this facility are working overtime to guarantee our beneficiaries receive the same top quality care we have provided for 103 years.

The nurses at Wurzburg MEDDAC are working overtime as well and are continuing with their patient care mission while the 67th CSH prepares to deploy in support of Operation Iraqi Freedom. As I toured the units and wards I met many active duty backfill nurses from Germany and the United States. The enthusiasm and “can-do” attitude of these individuals was infectious, and clearly demonstrated their ability to adapt to difficult and challenging circumstances.

The nurses at Landstuhl Army Medical Center are similarly demonstrating their flexibility while caring for the patients returning from Afghanistan, Iraq and other parts of the world. Their fantastic work over the past two years has directly resulted in saving many lives and assisting severely wounded soldiers back to a healthy state. Our great nursing staff is constantly developing innovative ways to improve care and facilitate the return of these heroes to their loved ones or back into the theater of operations.

As we celebrate the accomplishments of the Army Nurse Corps at anniversary celebrations around the world this month, please know that COL Gustke and I are exceptionally proud of your efforts to maintain the highest standards in patient care despite very challenging circumstances and conditions. The weeks and months ahead will bring us all more challenges as we prepare for the largest deployment/redeployment of American troops since World War II. We have proven time and again in our history that Army Nurses are trained and prepared, and COL Gustke and I know you are standing at the ready to accomplish the mission in your usual outstanding manner. We extend our gratitude to all of you.

Happy Anniversary,

**Bill Bester
BG, AN
Chief, Army Nurse Corps**

The ANC Newsletter is published monthly to convey information and items of interest to all Army Nurse Corps officers. If you have an item that you feel would be of interest to your fellow ANCs, please e-mail the articles to [MAJ Jeanne Larson](#). The deadline for all submissions is typically the last week of the month prior to the month you want the item published. All officers are eligible to submit items for publication. We reserve the right to review and edit any item submitted for publication.

***Continued Delays in Payment of New 2-year CRNA-ISP
by Bill Bester, BG, AN***

As many of you are aware, we are currently experiencing a delay in payments on the new 2-year CRNA-ISP contracts. I want all of you to know that the Army Nurse Corps and the AMEDD Special Pay Branch are working very closely with the Defense Finance Accounting Office (DFAS) to remedy this issue. The reason for the delay is the complexities of programming the DFAS payment system for this new pay option. I want to emphasize that this is a DFAS problem and not something that either the Army Nurse Corps or the AMEDD can correct independently. Although I do not know a firm date for resolution for this issue, I understand the frustration that many of you are feeling and appreciate your patience as we continue to work to resolve this issue as quickly as possible. Thank you.

POC for nursing special pay issues is Ms. Jessie Walton at OTSG: (703) 325-2376, DSN 221-2376,
jessie.Walton@amedd.army.mil

News Flash: Nurses Number One in Gallup's Ethics and Honesty Survey

Gallup's 2003 annual survey on the honesty and ethics of various professions shows that the public rates nursing as the most honest and ethical profession. Nurses outscored all the other professions with 83% of the respondents reporting that the ethical standards and honesty of nurses are "high" or "very high." This is the fourth time in five years that nurses are number one on the list. Keep up the great work!

Kudos

Congratulations are in order for **Brigadier General Deborah C. Wheeling**, Assistant Surgeon General for Mobilization, Readiness and National Guard Affairs. BG Wheeling was promoted on 12 January 2004 at the Women in Military Service for America (WIMSA) Memorial in Arlington, VA. BG Wheeling has served in a variety of active duty and Reserve component nursing leadership and clinical assignments within the Army Medical Department and her impressive biography may be found on the Army Medicine Website at <http://www.armymedicine.army.mil/default2.htm>



The **9A Designator** is a prestigious recognition by The Surgeon General of AMEDD professionals who achieve the status of expert in their respective clinical specialties. The nominee list has been approved by the TSG. Please congratulate the following nurses as they have earned a coveted honor:

COL Patricia Cordts (66F) Anesthesia, William Beaumont Army Medical Center
LTC (P) David Carden (66B) Community Health, Landstuhl Regional Medical Center
LTC (P) Teresa Parsons (66G) Maternal-Child Health, Ireland Army Community Hospital, Fort Knox
LTC (P) Richard Ricciardi (66P) Primary Care, USUHS PhD Program

The following nurses were selected during the supplemental **LTHET Board** held in December 2003. Congratulations to all as they continue to acquire the knowledge and skills necessary to fulfill increasing roles of responsibility within our Corps!

Nursing Anesthesia:

Beaumont, Denise	CPT	115 th /Ft. Polk
Buen, John	CIV	Direct Access
Clapper, Gilbert	CPT	10 th CSH/Ft. Carson
Clark, Thomas	Reserve	Called to AD
Dinh, Tim	CPT	274 th FST/Ft. Bragg
Estes, Savannah	ILT	BAMC
Ford, Timothy	Reserve	Direct Access
Frondozo, Robby	CPT	BAMC
Hoobler, Jimmie	CPT	BAMC
Johnston, Aaron	CIV	Direct Access
King, Tracy	1IT	LRMC
Robinson, Jennifer	CPT	MAMC
Weston, Eileen	CIV	Direct Access

Baylor:

Nagra, Michael	CPT	Ft. Sill
West, Gordon	CPT	WBAMC (deployed)

Family Nurse Practitioner:

Blaz, Daniel	CPT	Redstone Arsenal
Erazo, Hector	CPT	28 th CSH
Houston, Linda	CPT	115 th /Ft. Polk
Zuniga, Heather	CPT	Ft. Knox

Masters of Science:

Banks, Marie	CPT	USAM/Ft. Rucker, OB/GYN
Freeman, Julie	CPT	BACH, Ft. Campbell, Med Surg
Melvin, John	CPT	21 st CSH/Ft. Hood, Med/Surg

Congratulations to **MAJ Betty Egbert**, one of our dedicated Reserve mobilized nurses from the 369th CSH who volunteered and was selected to be the first Division Nurse for the 2nd ACR Regimental Support Squad currently deployed in Iraq. Great job, MAJ Egbert!

Congratulations to the newly selected **Training With Industry (TWI)** Fellows:

MAJ Janice Nickie-Green , William Beaumont Army Medical Center	RAND
MAJ Robert Durkee , Tripler Army Medical Center	JCAHO
MAJ Lisette Melton , Walter Reed Army Medical Center	JCAHO

Publications

COL Mike Custer from WRAMC Nursing Research Service was recently published in *Military Medicine*: O'Rourke, K., Roddy, M., King, R., **Custer, M.**, Sprinkle, L., & Horne, E. The impact of a nursing triage line on the use of emergency department services in a military hospital. *Military Medicine*, (168) 12, 981-985.

COL Anthony Ettipio was published in the October-December 2003 issue of the AMEDD Journal. The article's title is "The Japan Theater of Operation: An Overview by the U.S. Army -Japan Surgeon." You may access this at the following link: <http://das.cs.amedd.army.mil/PDF/J0310-12.pdf>

CPT Angelo Moore who is currently working in the Family Practice Clinic at Landstuhl Regional Medical Center in Germany was published in the December issue of *Military Medicine*. Boyles, G., **Moore, A.**, Quannetta, T. Health practices of male department of defense health care beneficiaries: A follow-up on prostate cancer screening in the national capital area. *Military Medicine*, Vol 168, No. 12.

LTC Susan G. Smith from Madigan Army Medical Center was published in *Diabetes Care* while she was assigned at Tripler Army Medical Center: Polonsky, W.H., Earles, J., **Smith, S.**, Pease, D.J., MacMillan, M., Christiansen, R., Taylor, T., Dickert, J., & Jackson, R.A. (2003). *Integrating medical management with diabetes self-management training*. *Diabetes Care*. 2003 Nov; 26(11):3048-3053.

MAJ Sara Sproat is currently serving as the DCA at Wurzburg MEDDAC in Germany and is the co-author of an informatics book available for advanced sale on Amazon.com. Hunt, Eleanor C., **Sproat, Sara B.**, Kitzmiller, Rebecca R. *Nursing Informatics Implementation Guide (Health Informatics.)*, Springer Verlag ISBN: 0387408371.

LTC Veronica Thurmond is currently assigned as a nurse researcher at Walter Reed Army Medical Center. The following article was a portion of her literature review for her dissertation study conducted at the University of Kansas. LTC Thurmond completed her dissertation in May 2003. **Thurmond, V. A.**, & Wambach, K. (2004). Understanding interactions in distance education: A review of the literature. *Journal of Instructional Technology and Distance Learning*, 1, 9 - 26.

Money for Education Available to Mobilized Reservists

DANTES will process payment (after-the-fact) for USAR personnel for the CEN exam (and others), including mobilized personnel. Other exam fees can be paid by the unit if the soldier has 1 year AD remaining and tuition assistance can be paid by the unit if the soldier has 2 years AD remaining. Please follow the instructions shown on the DANTES website: http://www.dantes.doded.mil/dantes_web/certification/usar_procedures.htm

News from the Front



(Left) One week prior to Christmas, the USO made a stop at LSA Anaconda in Balad, Iraq. Nurses from the 21st Combat Support Hospital donned festive hats and arrayed themselves with a sign sure to catch the attention of Robin Williams. The photo shows that indeed, they were successful. Pictured from left to right are CPT Kathi Hill, 1LT Rosemary Wosky, 2LT Angela Eagling (all from DACH), Robin Williams and MAJ Montez Gorrell-Goode (with the antlers, BAMC).

(Right) Members of the 21st CSH share their final bonfire with the newly arrived nurses of the 31st CSH. Songs, hot dogs and s'mores were enjoyed by all!



The Cost of Caring By Mary Brownfield, ICU Staff Nurse, Landstuhl Regional Medical Center

It was another busy day in the ICU. We'd been getting patients flown in to us from Iraq: young men and women with traumatic blast injuries. We generally treat and stabilize them before sending them on to Walter Reed Army Medical Center (WRAMC) in Washington, D.C. At WRAMC they will undergo further surgeries to revise their amputations and then begin long-term rehab in the use of the prosthetics that will replace their lost limbs. My patient was scheduled to fly that afternoon to Walter Reed. The air evac team would arrive around noon to package him up and I had a million things to do before then. He was a great kid; everyone's favorite in the ICU. But, despite all my efforts, things weren't going to work out the way I wanted . . .

Tim was in his early twenties; young enough to be my son. He had brown hair cropped short, dark eyes and a beautiful smile. He was confident and calm, with strength of character and charisma surprising in someone so young. He didn't show any fear or denial. He didn't whine. He looked at his right leg, amputated above the knee, and asked me to adjust the pillow under his stump (words that very few wounded can utter). He got to know all the staff and called us by our names. He told me how great everyone was and that we were his heroes. And he always said, "Thank you."

When Tim first arrived, the flight team helped me transfer him from the litter to the bed. I introduced myself and assured him I would take good care of him. He started to relax as I hooked him up to the monitor so we could read his vitals: heart rhythm, blood pressure, respiratory rate and oxygen saturation. The surgeon was in the room; he talked to Tim and explained what we were going to do. I sedated him and gave him some pain meds in his IV before we began cutting away all the bloody dressings to expose his wounds. He was a mess. His right leg was traumatically amputated above the knee and his left leg was full of holes. We weren't sure we could save it. He also had a broken arm and quite a few shrapnel wounds. We quickly cleaned his wounds and re-dressed them while the meds were still on board. He was pale and needed blood but otherwise appeared stable, requiring only minimal oxygen. Thank God he wasn't on a ventilator.

Later, when he was awake and we were alone, I asked Tim what happened. He had been in the Army less than a year and was in Iraq only a few months when the Humvee he was driving was blown up. He was in Mosul, part of a convoy moving through town. At the last minute, he saw what he thought was a bomb against the curb. It was too late. As he passed over it, the bomb was detonated remotely, firing forward into the engine. That saved his life but he still lost his leg. The front-seat

passenger was a medic. He immediately pulled Tim out of the vehicle and started working on him, keeping him from bleeding to death as he went into shock. Tim was tearful as he told me his story. He was shaken, but he was also upset that he couldn't thank the medic for saving his life.

We talked a lot over the next few days. He told me about playing outside as a kid, doing all the things boys do. He talked about his family and I could feel the respect he held for his parents. When I showed up for work in the morning, he reached out to hug me with his good arm. We joked around and played games with each other. "You're the best," I told him. "No, you're the best," he said. "But you're the best-est," I always said next. And then we'd laugh. We laughed a lot together. One day, though, I explained how they would put him to sleep in the O.R. and clean and dress his wounds. I couldn't go with him but I reassured him I would be with him when he woke up. He was nervous. I held his hand as they wheeled him out of his room to the O.R. and he squeezed my hand. Hard. When he came back, I began the recovery process: assessing and re-assessing him, monitoring his breathing, taking his vitals repeatedly. The surgeon had to shorten his right leg a little more while he was in there and I was checking his dressings for any bleeding. All the while, I stroked Tim's head and spoke to him softly as he woke up, saying over and over, "It's OK, Tim. Your surgery's all over. You're just waking up. You're back in your room, Tim. This is Mary. I'm taking good care of you. Everything's OK, Tim."

But this morning there wasn't a lot of time to joke around. Looking over his labs, I saw that Tim's hemoglobin and hematocrit were low. He was going to need blood before the air evac doc would let him fly. The ICU surgeon ordered two units of blood. Tim was tachycardic and running a temp, too - a little over 100. The blood might help with the fast heart rate, but the doc wouldn't let him fly if his temp was 101 either. Things were stacking up against us. I desperately wanted him to fly that day. I'd talked with his folks over the phone and, naturally, they were worried sick about him. They were planning to meet him at the hospital in D.C. I wanted him to get going so he could get on with the long process of healing. I wanted the best for him.

The charge nurse told me, "Mary, it's time for you to work your magic."

"I know, I know. I'll do my best," I said. "Now let me go to work."

I drew some blood for a new type and cross. His old clot had just expired. That was going to cost me an hour while they ran the tests. I ran the paperwork down to the lab and explained I was desperate, would they please call me as soon as the blood was ready? Back in the room, I checked Tim's temp again. It was creeping up. I put a wet cloth on his forehead and turned the fan on him. Everyone was stopping by to say good-bye, to wish him luck. Meanwhile, I was getting his flight meds together and worrying if he was even going to make it. As soon as the lab called, I ran back downstairs to get the first unit. I already had the IV tubing primed and ready to go and I had the blood up in minutes after checking it with another nurse. I had to start out slow and watch Tim closely for any signs of a reaction while monitoring his blood pressure and temperature every five minutes. His temp was climbing - this was not good. He looked fine, a little pale, but I didn't suspect a reaction to the blood. Even if I could get all the blood into him on time, he still might not be able to fly because of his fever. I sent someone down for the second unit while the first one was finishing up. I was working against the clock but I was making it. Second unit up, checking for any reaction, Tim's temp was 101 and he was still tachycardic. I touched base with the ICU surgeon again. He was going to keep Tim in the unit. He was too unstable to fly. I tried to protest, but I knew he was right. My co-workers started to laugh, joking that I had packed my patient with tons of ice to try to lower his temp.

Now I had to go tell Tim. It was going to be tough to hide my emotions from him. We knew each other too well by then and besides, I'd been explaining everything I was doing and what was going on. He looked up at me as I walked in his room.

"What is it, Mary?" he asked. I could hear the concern in his voice.

"Tim, the doc says you can't fly today," I told him. I watched the disappointment flicker across his face. "Your temperature is over 101 and your heart is racing. He says he can't send you like that. What if you got worse somewhere over the Atlantic? It would be very difficult to treat you in flight and we sure don't want to lose you. I'm sorry. I wanted you to fly today so bad. I'm so upset I could just about pitch a fit."

He looked me straight in the eye and said quietly, "No you won't. I'll make it out on the next flight. You're gonna keep it together and when that next soldier comes rolling in, he's gonna be lucky to have you for his nurse, 'cause you're gonna take care of him just like you've taken care of me."

He stopped me right in my tracks. I wanted to say that he didn't understand, he wasn't just another soldier, he was someone very special, everyone could feel it. But I didn't. And he was right. There would be another soldier rolling in the door, and another, and another, and another. The second unit of blood was still infusing. I checked Tim's blood pressure and temperature again and recorded them in the chart, my heart in my throat and tears in my eyes.

***TDY to Kosovo: A nurse's experience
by 1LT Cecelia Theresa Perez, AN***



In October, I deployed to Kosovo for six weeks to work as an emergency room nurse at Camp Bondsteel. I assisted in the transition of "Task Force Medical Falcon (TFMF) VIII" to "TFMF IX." This meant that I worked in the medical facility during the period in which one reserve unit (TFMF VIII) prepared to leave after eight months of deployment from their home units in California and Pennsylvania. Meanwhile, another reserve unit (TFMF IX) from New Jersey and New York arrived and began to learn the ins and outs of the hospital.

Immediately after hearing of my assignment, I scanned the Internet for information on what I knew to be a catastrophic history in the Kosovo area. I found a lot of information on the background, region and issues which erupted into bitter fighting between two ethnic groups, the Serbs and the Albanians, in a land formerly known as Yugoslavia. Intervention by NATO forces was ultimately needed to prevent escalation of this conflict and stop ethnic atrocities in a humanitarian crisis. Peacekeeping forces to this day continue to stabilize the area and along with the medical component, Task Force Medical Falcon, provide treatment and medical care for the US and NATO's multinational troops in the area. An important part of the mission is

to serve as a role model to the people of Kosovo in a spirit of multiethnic cooperation, interaction and fellowship.

Camp Bondsteel has a fully functional, level III hospital with a four bed Emergency Room, an ICU, two operating rooms and a variety of specialized services such as pharmacy, radiology, preventive medicine, and ground and air evacuation. The camp is well known for its wide variety of excellent medical care as well as its fine dining facility and a 24-hour a day gym. Of course, the potential dangers of the area are also well known as illustrated by examples of the various "land mines" which are on display throughout the camp and conspicuously positioned (e.g. in the lobby of the dining facility and at the entrance doors to the gym).

Because I have been a nurse for many years (although new to the military, having joined in a state of patriotic fervor after the events of 9/11), my experiences in the ER were fairly routine. However, my work at the hospital kept me busy with four to five 12-hour shifts in a row and it was during my off duty time when I was fortunate enough to venture out on patrol to a town that stands out in my memory: Vitina.

Early one morning, I joined four soldiers and an interpreter on a two-humvee tour through landscape, which appeared at times both fertile and desolate. Small areas of farmland looked tilled and readied for fall planting but other vast stretches of land lay weary and neglected. Houses without doors or windows, or with missing walls, dotted the horizon as many of these homes had been abandoned to decay or were in the early stages of reconstruction without sufficient funds to complete them. The downtown area of Vitina on market day was our destination and proved to be quite a mystery. Young people were packed into smoky cavernous coffee houses (one had a babbling brook running through it) and in the streets old women, heads covered with babushkas, strolled arm in arm examining row upon row of every item imaginable from gold trinkets and crochet linens to CDs, livestock and mountains of cabbages overflowing from produce carts.



The children of Vitina, Kosovo, gather in their schoolyard to visit with American soldiers.

As part of our patrol, we investigated what turned out to be unsubstantiated reports of the flying of the "Albanian" flag, which is not permitted in this ethnically conflicted area. We continued on from the market place to a Serbian school where one of the soldiers, well known and liked by the children, had been asked to give a US history lesson to illustrate the successful blending of nationalities into the melting pot known as the United States. The classroom was small with no lights and was heated by a potbellied wood-burning stove. The children looked thin and frail but were dressed warmly and cheerfully responded with the help of the interpreter to information presented by their new teacher. They were surprised to hear each American soldier list two or more different nationalities to describe our ethnic heritage. Following class, we emerged onto the playground, which amounted to a little more than a muddy field with a few rusted swings where more and more children had gathered as news spread of the presence of the American Soldiers. There seemed to be a paternal bond between the Soldiers and the children as "high five's" were exchanged and communication succeeded across the language barriers.... and then there was candy!

I had been told to bring along candy for the trip. I wasn't sure when would be the best time to hand it out and the patrol was winding down. I asked the interpreter if now would be a good time and he gave me a wary look. Had I brought enough for everyone? I thought I did at first but after giving out a few pieces, I was overwhelmed by children who multiplied exponentially by the minute. I was on the verge of being buried alive under a mountain of children when the interpreter rescued me by taking the bag of candy from my hands and tossing it out behind us, which sent the children scurrying towards it and off of me. I soon learned that almost as much as candy, the site of a camera thrilled the children, too. They all wanted to be in a picture and were perfect hams in front of the lens. Certain things seem to be universal.

The children were relentless and followed us back to our humvees. I was preparing to sit back and digest the multitude of emotions that had been stirred in me by the day's events on the long, slow ride to camp. Just before our departure, one of the kids was asked via the interpreter what he wanted to be when he grew up. The child's enthusiastic response: "An American Soldier." I knew it had been a memorable day.

ANC Historian Section
CPT Lauren A. Otto, Army Reserve IMA

When I entered the Army Nurse Corps ten years ago, I knew one thing for certain: I was embarking on a career that would change my life. And it has! A couple of key experiences in the last ten years have greatly influenced where I am in my career and in the Army Nurse Corps today. I'm currently a doctoral nursing student at New York University and last summer, I was nominated into the Army Reserve IMA position of the Army Nurse Corps Historian.

From the beginning, I had only one location in mind for my first Army nursing assignment – I told my nurse counselor on the University of Minnesota campus that my first assignment had to be Walter Reed Army Medical Center in Washington, DC. It was at OBC that I first learned from a fellow Second Lieutenant that the Army Nurse Corps had a historian located in Washington DC. I knew then that I would begin finding out more about that position as soon as I reached Walter Reed. Then a Major, LTC (P) Constance Moore was the ANC Historian at the U.S. Army Center of Military History. I volunteered to help in her office and she opened up a whole new archival world to me. I was hooked! The photos, the original correspondence, and especially the oral histories – it all made a lasting impact on me. Thank you, LTC (P) Moore!

Since 1994, I've also volunteered with the Vietnam Women's Memorial Foundation (VWMF). The heroic examples and immense sacrifices of the women of the Vietnam era were and are compelling to me. President and Founder of the VWMF, Diane Carlson Evans, and VWMF Vice President, COL Jane Carson (USA, Ret.), are two of these women. The VWMF celebrated their 10th Anniversary of the dedication of the memorial at the Wall in Washington, DC this past November and I knew this was an opportunity to capture history. With the help of the Library of Congress' Veterans History Project, the VWMF collected approximately a dozen oral histories from women who served during the Vietnam era in a variety of capacities, both overseas and stateside, both military and civilian.

At New York University, I plan to use the oral history method as my means of collecting data for my dissertation in military nursing history. An expert in the oral history method, my doctoral advisor is Elizabeth Norman, author of *Women at War: The Story of Fifty Military Nurses Who Served in Vietnam 1965-1973* and *We Band of Angels: The Untold Story of American*

Women Trapped on Bataan by the Japanese. Dr. Norman's guidance and expertise is invaluable.



My current assignment as the IMA Army Nurse Corps Historian includes collecting oral histories from current AMEDD personnel, military and civilian, in the National Capitol Region. Their experiences in response to the Global War on Terrorism and Operations Enduring and Iraqi Freedom are captivating. Each person's unique experiences and sacrifices are the critical pieces of the puzzle that provide more insight into the successes of the Army Medical Department.

As the Army Nurse Corps celebrates its 103rd birthday this month, I hope each of you will consider not only how your predecessors shaped today's ANC, but also how *your* experiences will shape tomorrow's Army Nurse Corps.

Picture caption: VWMF 10th Anniversary Celebration 1:00PM Program at the Vietnam Veterans Memorial, Washington, DC, 11 November 2003; Left to right – Diane Carlson Evans (President & Founder, VWMF), ADM William Crowe, Mrs. Shirley Crowe, and Elizabeth Norman. ADM Crowe, former Chairman of the Joint Chiefs of Staff, and Dr. Norman, NYU Professor and Doctoral Nursing Program Coordinator, were keynote speakers during the 1:00PM program.

Through the Years: Words That Have Commemorated the Army Nurse Corps Anniversary
By MAJ Jennifer Petersen, AN



This month, the Army Nurse Corps celebrates its 103rd anniversary. The history of military nursing in America can be traced to the War of Independence and General George Washington's request for funds to employ "one nurse to every ten patients." Following the establishment of the Army Nurse Corps in 1901, annually the organization has honored the 2nd of February as its official anniversary. Throughout the years, many have offered words that eloquently express the undeniable legacy of the Army Nurse Corps. What better way to honor the passing of yet another year of Army Nursing service to our Nation than with words from the past? During the celebration of past anniversaries, the following quotations recognized the admirable service of Army nurses. With these words, we salute past and present Army nurses around the world.

"We look on you not as a personality but as a wonderful composite that spells peace, security and home. You are to our morale as a cast to a withered limb. You enable us to walk, think, and hope again. With millions of men around us, we have been alone. Now you have made us feel once more a part of humanity." (An American soldier somewhere in England, February 1945)

"Since February 2, 1901, Army nurses have served with American troops all over the world. In peace and in war they have shared all of the hardships and dangers of military service. Due to their skilled care, losses from combat have been greatly reduced. Their willingness to share the dangers of service has been an inspiration to all soldiers." (Lieutenant General J. H. Collier, February 1956)

"We in the Corps must exercise the same foresight and vigilance which was shown by our predecessors in order to continue to carry out our ever increasing responsibilities. This same esprit de corps is found not only in primary duties of assisting the doctor and in giving patient care, but also in various clinical specialties, staff work, and research work. The Army nurse continues her professional education with this spirit as a variety of military, clinical, and administrative courses are made available. Because of these educational opportunities and by using the knowledge gained from this training, the Army Nurse officer can meet the responsibilities wherever she is assigned. (COL Margaret Harper, February 1961)" "In this Bicentennial year of our Nation's history, the men and women of the Army Nurse Corps continue to uphold a long and proud tradition of service. Army nurses of today are literally world citizens as well as contributing citizens in their local communication. Their horizons and experiences are worldwide. They are concerned about international and local affairs, resources and the needs and



BG Bester and COL Gustke accepting the flag flown over the United States Capitol in honor of the 100th Birthday of the U.S. Army Nurse Corps,

worth of the individual. They are concerned about peace in our time and hope for respite from wars as we enter the third century of our nation's Declaration of Independence. They think for themselves, blending old ideas with new ideas. They are courageous, versatile, and mature. Their practice is patient, family and community centered. They are responsive to the challenges of the nursing profession as it continues to grow, expanding its body of knowledge and experience. Army nurses, past and present, have followed and will continue to follow the Army Nurse Corps pledge: As an Army nurse... I shall bring to the American soldier, wherever he may be, the best of my knowledge and professional care." (Brigadier General Madelyn M. Parks, February 1976)



"In the zero hour of democracy, you landed with American troops. In one capacity or another, you treated the bleeding feet that stained the snow at Valley Forge. But, Valley Forge was only the beginning. There was much to follow: the War of

1812, the Civil War, the Spanish American War...hot wars, cold wars, and all of them horrible wars. Where brave men fought, you were their giving sulfa and plasma. You heard men scream in anguish and pain. You are many, yet, you are one. You are buried in Arlington and you are alive on every continent. From Concord Bridge to Heartbreak Ridge: from the Artic to the Mekong. You are young and you are old... and, for you, there can no letup in time of peace and, indeed there much be no let down in time of war. You are the Army Nurse.” (COL Reinard W. Beaver, Chaplain, Madigan Army Medical Center, February 1983)

For 93 years, the Army Nurse Corps has bravely trudged through conflict, disaster and disease, content to work behind the scenes and support the troops. Its men and women aren't the stars of the show, but those who have felt their healing touch will never forget that moment of comfort in a faraway land.” (American Forces Information Service, February 1993)

Historical Data located at the Army Nurse Corps Collection, United States Army, Office of Medical History, Office of the Surgeon General, Washington D.C. January 2004

***News from the MEDCOM NMA: Dispelling WMSN Myths
by COL Katherine Babb***

This past summer I assumed the position of the MEDCOM Nurse Methods Analyst (NMA) and quickly identified a topic with significant impact on the Army Nurse Corps and the Army Medical Department (AMEDD): The Workload Management System for Nursing (WMSN). The purpose of this article are to dispel two common myths regarding WMSN and to initiate a crusade to improve WMSN data quality.

Myth #1: No one uses or even looks at WMSN data. *The MEDCOM Manpower Division uses WMSN data for the Automated Staffing Assessment Model's (ASAM) inpatient module.* The research-based ASAM was developed to provide a standard methodology for determining all TDA requirements within the AMEDD. WMSN was selected as the basis for the inpatient module because it is an information system for determining staffing requirements based upon patient care needs that through extensive research was deemed valid and reliable. WMSN is available in all Army MTFs with inpatient missions except Brooke Army Medical Center (BAMC); BAMC has a WMSN-based system that employs WMSN formulas and determines staffing requirements identical to WMSN. WMSN provides the Manpower Division with a standard methodology to assist in determining inpatient TDA requirements AMEDD-wide.

Myth #2: WMSN is going away soon. *It is estimated that WMSN will remain the AMEDD's corporate patient acuity system through 2008.* The Military Health System (MHS) has chartered an Enterprise Wide Workload Forecasting (EWF) Working Integrated Project Team (WIPT) to work towards procuring an integrated workload forecasting information technology solution. For various reasons, progress has been slow and the deployment date of the Enterprise Wide solution, which is to include both an inpatient and outpatient acuity system, has been pushed back numerous times. WMSN is the only AMEDD-wide patient acuity system available and will not be replaced for at least four years.

On to the crusade: I am aware that WMSN is not highly regarded by many people. I believe this is due to two crucial misconceptions about WMSN: 1) a belief that WMSN should yield requirements for peak workload--manpower requirements represent the minimum essential numbers of positions needed to accomplish mission responsibilities (staffing levels are based on average workload), and 2) a belief that WMSN alone should yield all the requirements needed on a nursing unit. WMSN does not take into account additional missions a unit's personnel must assume that are beyond the purview of inpatient care; such missions should be captured in UCAPERS. WMSN cannot capture factors such as the impact of staff experience level and unit architecture and configuration; nursing managers must consider such factors, in addition to WMSN, when making decisions regarding staffing. WMSN is a management tool that must be tempered by additional information unique to a unit, its staff and/or its patients.

It is imperative that MTFs with inpatient missions initiate measures to improve the reliability of their WMSN data. Nursing personnel must understand the critical indicators that are used to classify their patients and, all units should conduct quarterly Inter-Rater Reliability tests to ensure that patients are being correctly and consistently categorized. Descriptions of critical indicators and guidelines on conducting Inter-Rater Reliability Testing can be found in the “Workload Management System for Nursing” (WMSN) manual found on www.ampo.amedd.army.mil; click on the WMSN-A tag on the left side of the home page and view the documents on Inter-Rater Reliability Testing and critical indicators. I highly recommend monthly IRR testing for a period of 4 to 6 months for facilities that have not been routinely conducting IRR tests to help establish a sound process. Please call me at DSN 471-7210, commercial (210) 221-7210, or e-mail me at katherine.babb@cen.amedd.army.mil if you have any questions. REFERENCE AR 570-4, Manpower Management, 15 May 2000.

Community Based Health Care Organization Update
By COL Carol Swanson, MEDCOM Case Management Support Office

I am receiving many questions from the field on the Community Based Health Care Organization (CBHCO) Initiative, which will be implemented on 1 March 2004. This Initiative authorizes state-based CBHCOs that will manage the care of Medical Holdover (MHO) Soldiers closer to their homes. This is a pilot program with 10-14 states identified and the first to stand up is Florida on 1 March.

The CBHCOs fall FORSCOM with command and control through the 1st or 5th Continental United States Army (CONUSA). Mobilized soldiers from the Army National Guard (ARNG) will staff the CBHCO. One AN Case Manager (CM) for each 50 MHO (10 per CBHCO) is authorized for mobilization. The Regional Medical Command (RMC) will be a resource to the CBHCO in their respective regions. FORSCOM will mobilize a senior case manager from the Army Reserve to assist the RMC with this responsibility. These CMs have already been identified.

The MHO case managers currently assigned to the MTF will be responsible for the coordination of the medical plan of care from the MTF to the CBHCO case manager. There will be administrative/PAD ARNG personnel mobilized to coordinate the transfer. A mobilized Army Reserve soldier, most likely a CM, will be a liaison to the CBHCO. ALL MHO, both ARNG and Army Reserve soldiers in the CBHCO will be monitored in MODS. All documentation currently required in the MHO/ADME module of MODS for MHO will be required for CBHCO Soldiers.

Questions and comments may be directed to COL Carol Swanson at 210-221-8219 or carolswanson@us.army.mil.

Infection Prevention and Control Meets JCAHO Consultant's Corner
Jane Pool RN, MS, CIC

Whew! 2003 is gone and the new year brings along significant changes in the way in which our MTFs are surveyed by JCAHO. At a recent conference attended by several Army Infection Control Practitioners, we learned about this evolving process.

Remember lugging all those policy books, logbooks of sterilization records and committee meetings to a central location for the “***Document Review?***” History. Instead, you will be required to forward certain documents in advance for their preliminary review. And don’t forget the dreaded one-hour “***Infection Control interview with the surveyor***” – one on one? History. Remember those long nights spent gluing PowerPoint prints to a large piece of poster board for “***The Storyboard?***”... History. On opening day of the survey, you will have a limited time for the presentation of one performance improvement project – and you had best “***show me the data!***”

Tips for successful survey: Systems support must be evident and it’s all about the responses given by the clinical staff the surveyors talk to in the hospital. Focus on training the troops in the trenches. Make sure all **checklists are 100%** (Refrigerator temperatures, code carts, sterilization records, spore tests, etc.). If they find small errors on the sheet for the current month, the surveyor will expand their review to at least the previous twelve months.

First Impressions Count! Clean house. If the facility looks dirty or cluttered – the surveyors will look much closer. Last year, one facility was cited for tape residue on an IV pole – it could happen to you!

How are you measuring compliance with the **hand hygiene guideline**? Some MTFs are calculating the volume of alcohol hand rinse and soap purchased and some are visually monitoring the actual numbers of times compared to opportunities for hand hygiene.

As a part of the new *Tracer methodology*, there will be an **Infection Control Systems Tracer** conducted at the MEDCENS and a **Dated Use Tracer** at the smaller facilities. These involve looking back at all the steps in the process for a patient undergoing surgery. Was the timing of antibiotic prophylaxis within the hour before the first incision? What was the duration of postoperative antibiotics? What is your protocol for surgical site dressing changes? These will involve all individuals involved in the pre and post operative care of the surgical patient being evaluated and they will review the case of a patient with a surgical site infection.

Under the sink -The moisture and condensation from the exposed pipes can contaminate any items stored there. Cleaning supplies are OK, but this is only acceptable for areas where there is no possibility a child could access the area. For areas undergoing new or reconstruction, it is best to recommend a freestanding sink against the wall. Install a more useful cabinet

elsewhere in the room so that the counter surface can be utilized without risk of water splash contamination and the underneath storage can be maximized.

Cubicle curtains – What is your policy for the frequency of cleaning? Based on many factors, regularly scheduled washing and whenever visibly soiled is the process. Some facilities require privacy curtains in an Isolation room are terminally cleaned after each discharge.

The surveyors will want to see evidence of a multidisciplinary, team approach to **Occupational Health**. What is your organization doing to monitor the screening and immunization of your active duty and civilian employees? The same standards also apply to the contract staff. Verify that all temporary staff are appropriately credentialed; are assessed for competence; meet the same immunization standards as permanent staff; and are effectively oriented and monitored. A new JCAHO certification program will be underway in the fall that will provide assistance for ensuring the same standards for staffing agencies as permanent staff is met.

More teamwork is required for the development of a **hospital antibiogram**. Optimally, the Lab, Pharmacy and IC staff all have input to this annual document that describes the “fingerprint” for the microbiological isolates unique to your facility. JCAHO wants to see how this document is utilized in the MTF. How is this information shared among the professional staff and do you monitor trends in the physicians’ antibiotic prescribing patterns? Does it outline and guide first line treatment? Does your hospital have formulary restrictions for certain antibiotics? The actions taken by all healthcare providers to help decrease antibiotic resistance will be a major focus in 2004 and even more so in 2005. AND, what is your blood culture contamination rate? More than a 3% requires action.

Often outcomes are personality dependant – if the surveyors challenge you about your processes, politely request the reference that requires this. If you can demonstrate that your evidence-based policy and your practices match, you should be OK.

REFERENCE: <http://www.jcaho.org/accredited+organizations/accredited+organizatio ns+.htm>

Clarification Regarding Papers Submitted for PJV Research Awards Program

There has been some discussion as to format for papers submitted for the Phyllis J. Verhonick Research Awards Program. The call for papers states, "The award winning papers will be submitted to *Military Medicine* for review and publication". We recognize that *Military Medicine* may not be the best venue for some papers; other peer reviewed journals may better represent your work and submission to them is entirely acceptable. When you submit your paper for the PJV, please state to which journal you intend to submit your paper and follow their author guidelines. Papers are due NTL 25 Feb 2004. POC: Deborah.Kenny@amedd.army.mil

ADVANCING NURSING PRACTICE: Putting Evidence Into Nursing Practice By LTC Deborah Kenny

Collecting Data for Guideline Development and Implementation: Data collection is a very important part of Evidence-Based Practice (EBP) guideline development and implementation. It provides both the beginning point of reference against which you will be working and allows an objective measure of success in implementing new guidelines. You will want to examine several aspects of the topic area you have chosen. Measurement of the knowledge level of nursing personnel about the topic will reveal areas where staff education is needed. Examination of current care practices will show exactly what is being done in you facility and how much variation in practice is present. Assessment of care documentation may disclose areas where additional tools and/or cues for documentation would be helpful.

The information to be collected should be based on your literature review. For example, if you are looking at wound care and the literature is showing that one type of dressing for wounds is better than another, data should be collected on the types of dressings used in your facility, including those the literature is supporting. By using the literature reviews to guide your data collection, you will be benchmarking your data against the evidence.

Data should be collected several times throughout the process of putting evidence into practice and this is generally considered to be a part of the performance improvement process. Ideally, it should be collected before the guideline is developed and implemented, a short time after the guideline has been put into place and several months to a year after implementation. There are several reasons for the timing and types of data collection. They will be discussed below.

Initial data collection is done before the guideline is developed. It provides two types of information. First, it provides a baseline assessment of current practice in your facility. Practice may vary from ward to ward and even from individual to

individual. Second, it will show areas where education and staff assistance are needed to make the change. For example, a short quiz, based on the literature and given to nursing personnel could serve as a competency assessment and help in the development of a relevant educational program.

Data collection should be repeated again shortly (within 2-3 months) after the new evidence-based guideline is implemented. This will allow you to determine if the change has been successful (i.e., is there now consistent practice throughout the facility, allowing for unit specific adaptation, or are all essential aspects of care consistently documented). It may also begin to show trends toward improvement in outcomes. It can also provide an evaluation of how well the process is going and where there may be gaps. A third data collection should be carried out several months to a year after the implementation of a new guideline. This will assess continued sustainment of the change and demonstrate long term outcomes results.

Not only is collecting data important for the process of using evidence in practice, but it will soon be a requirement for JCAHO accreditation. By its natural incorporation into EBP, data collection provides the necessary information for patient care improvement. Walter Reed is in the process of developing several EBP guidelines and would be happy to share data collection instruments or information. In addition, anyone having specific questions they would like to see answered in this column by evidence-based nursing practice experts, or those wanting to share stories of implementation successes, tips or lessons learned can submit them to me at deborah.kenny@na.amedd.army.mil or contact me at Comm: (202) 782-7025 or DSN 662-7025.

***ABSTRACT: An Examination of the Prostate Cancer Screening Practices of Military Servicemen
By LTC Hyacinth Joseph and LTC James Hickey***

Background: Every 24 hours, prostate cancer claims the lives of over 80 American men. The American Cancer Society (ACS) recommends annual screening with the Digital Rectal Examination (DRE) and the Prostate Specific Antigen (PSA) test for all men 50 years of age or older. Men at risk (especially African Americans and those with a close blood relative diagnosed with prostate cancer at an early age) should begin screening at age 45. Since the Department of Defense (DOD) does not have a policy for prostate cancer screening, this study was conducted to assess the level of compliance with the current ACS guidelines.

Research Methodology: This descriptive/retrospective study examined the prostate cancer screening practices of military servicemen, age 50 and older, who were seen in three Outpatient Clinics at Tripler Army Medical Center over a 24-month period. Data was obtained from three sources: (a) the Clinical and Economics Outcomes (CEO) Database (b) The Composite Health Care System (CHCS) and (c) Outpatient Medical Records. The CEO Database is a local automated system that integrates clinical data from CHCS and the Ambulatory Data System (ADS) and makes them available to providers. When information such as race/ethnicity and PSA screening was not found in the outpatient records, the Investigators cross-referenced in CHCS under "laboratory results" and "patient information". A randomized process was used to select outpatient records for inclusion in the study. Data was collected using a data-sheet developed by the investigators. Two research questions were explored: (1) what are the overall prostate cancer screening practices of military beneficiaries? and (2) what are the screening practices based on age, ethnicity, and military status? Data was analyzed using descriptive statistics.

Study Findings: The sample was predominantly military retirees (n = 494 or 99.5%), with one active duty and one family member. Men over age 67 represented the largest segment of the sample and were predominantly White (n= 206 or 42%) and Asian/Pacific Islander (n = 93 or 19%). Representation by African Americans, Latino Americans and Hawaiians accounted for less than 7% of the total sample. Thirteen percent of the sample (n = 66) had no documentation of their ethnic/racial affiliation either in their medical records or in CHCS. Of the 496 records reviewed, 68% (n = 331) had evidence of the PSA Test and 18% (n = 90) had documentation of the DRE. Combined use of the PSA and DRE was evident in 13% (n = 65) of the medical records. As men over age 67 represented the largest portion of the sample (n = 346 or 70%), they also had the highest screening rates for the study (n = 229 or 46% for PSA and n = 66 or 13% for the DRE). All other age groups were almost evenly divided in their rates of both PSA and DRE screening. Similar to the ethnic/racial composition of the sample, Whites and Asian/Pacific Islanders reflected the largest portion of screening (Whites n = 184 or 37% for PSA; n = 46 or 20% for DRE, and Asian/Pacific Islanders n = 81 or 16% for PSA and n = 23 or 5% for DRE). Screening with the PSA for African Americans, Latino Americans and Hawaiians was at least 50% or greater for each group (but the actual numbers screened were quite small). The DRE screening rates were much lower.

Implications: There are opposing views on prostate cancer screening. However, since January 2001, the Army has been offering the PSA test to men during their over 40 mandatory physical examination. A 13% compliance rate with ACS guidelines clearly underscores the need for a definitive DOD screening policy. Further, patients should be educated so that

they can make informed decisions about participating in screening. Studies are also needed to explore specific reasons for the low participation in early detection screening by ethnic minority patients, especially those from high-risk groups.

The views expressed in this abstract/manuscript are those of the authors and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government.

Army Nurses: Please share your MOOTW experiences . . .

Have you ever wondered where research ideas come from? Well, a new study that is under the direction of LTC (Ret) Janice Agazio, had its origins right here in the Army Nurse Corps newsletter. During 2000-2001, letters and stories were published in the newsletters from nurses stationed in Kosovo and Bosnia detailing some of the patient care requirements and nursing challenges. From reading these personal accounts, Dr. Agazio, who is now on faculty at Uniformed Services University, began to wonder if there were differences in nursing care provided during Military Operations Other than War (MOOTW) or humanitarian deployments. She also thought that, as part of the project, some “lessons learned” could be compiled to assist in training and preparation to help other nurses deploying to similar settings.

These questions led to a grant proposal that was funded in 2002 by the Triservice Nursing Research program and will be conducted by a team of Army Nurse Corps officers to include COL Laura Brosch, LTC (P) Karen Gausman, LTC (P) Beverly Cornett, LTC (P) Richard Ricciardi, and LTC (Ret) Becky Torrance.

Unfortunately, with the war in Iraq, the start of the project was delayed. So now, the project is ready to begin and the team needs volunteers, both active duty and reserve component nurses, to participate in an interview, in person or by phone, to share stories of MOOTW experiences. Since ANC’s have also served in Operation Iraqi Freedom in the interim, the research team is also interested in comparing wartime nursing experiences with those from MOOTW deployments. Please consider volunteering to assist LTC (Ret) Agazio and her team with this project. More information regarding the study is posted at the end of the newsletter. She can be contacted at the USUHS Graduate School of Nursing at 301-295-1004 or jagazio@usuhs.mil.

Human Resources Command (HRC) Update

Army Nurse Corps Branch Web Page

The direct address for our web page is: www.perscomonline.army.mil/ophsdan/default.htm Please visit our website to learn more about the AN Branch and for matters pertaining to your military career. You will be forwarded to the HRC Website until all links are completed.

Upcoming Boards

FEB 2004	CPT/VI
MAR 2004	LTC AMEDD
JUN 2004	SSC (SPECIAL BRANCHES)
JUL 2004	COL AMEDD
JUL 2004	CSC (SPECIAL BRANCHES)
JUL 2004	HPLRP
OCT 2004	LTHET

See HRC Online www.perscomonline.army.mil for MILPER messages and more board information.

As the Board process continues to evolve, the AN Corps must upgrade its preparation process to ensure our records are seen in the best possible light. Board members view three items; the ORB, Photo and Microfiche. These items are at your fingertips via the following links using your AKO USERID and PASSWORD:

<p>Officer Record Brief https://isdrad15.hoffman.army.mil/SSORB/</p>	<p>DA Photo (only if your photo was taken after 1 OCT 02. Earlier photos will be in hard copy here at branch until the board file is prepared by the DA Secretariat) https://isdrad15.hoffman.army.mil/dapmis/execute/ImageAcceptProlog</p>	<p>Official Military Personnel File (OPMF previously know as your microfiche) https://ompf.hoffman.army.mil/public/news.jsp</p>
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Command and General Staff College	
<p>Army Reserve Component: Phases 1 and 3: Contact Jennifer West at 703-325-3159. Phases 2 and 4: Fax a DA 3838 to LTC Diaz-Hays at 703-325-2392.</p>	<p>CGSC Correspondence Course: https://cgsc2.leavenworth.army.mil/nrs/cgsoc/application/application.asp You must have an AKO password to enter the site.</p>

Education

Reminder: that all education requests should come through your facility's education department. The revised LTHET guidelines will be available on the Website this month.

Generic Course Selection Program

Information on GCSP is located in our website https://www.perscomonline.army.mil/ophsdan/anc_profdevt.htm

AOC/ASI Producing Courses			
<p>Critical Care Course, Emergency Nursing Course: Applications for the MAY 04 Critical Care and Emergency Nursing Courses must be submitted by 5 December 03. Course dates for 2004 are: 18 Jan-27 Apr 04; 23 May-31 Aug 04; 26 Sep 04- 21 Jan 05. POC is LTC Corulli at HRC, corullia@hoffman.army.mil.</p>	<p>OB-GYN Nursing Course:* The 2004 Course Dates are: 5 Jan- 27 Apr '04 (course has been filled); 10 May- 31 Aug '04; 13 Sep- 21 Jan 05 Contact MAJ (P) Agin at agind@hoffman.army.mil (please check the website for application due dates)</p>	<p>Psychiatric-Mental Health:** The 2004 Course Dates are: 5 Jan- 27 Apr '04, 10 May- 31 Aug '04; 13 Sep- 21 Jan 05 Contact MAJ (P) Agin ASAP: agind@hoffman.army.mil.</p>	<p>Perioperative Nursing Course: There are still seats available for the 14 March 2004 class. The next class will be 1 August 2004 through 24 November 2004. For any questions, please contact LTC Jane Newman at HRC @ newmanj@hoffman.army.mil. For current assignment opportunities, visit https://www.perscomonline.army.mil/ophsdan/anc_assignments.htm</p>
<p>Interested applicants for the above courses need to seek support from their chain of command and submit a DA 3838, a recent HT/WT/APFT memo and a preference statement (for follow on assignment). Please check the AN branch web site at www.perscomonline.army.mil/ophsdan/default.htm (click on professional development) for information on application suspense dates to AN branch or contact LTC Corulli, corullia@hoffman.army.mil or MAJ(P) Agin at agind@hoffman.army.mil.</p>			
<p>*(66G) OB/GYN Duty Locations- This is a list of all the MTF's that have OB/GYN services-please use this list when filling out preference statements: Korea-121 Gen Hospital; Tripler AMC, Hawaii; Heidelberg, Germany; Landstuhl, Germany; Wuerzburg, Germany; Anchorage, Alaska; Ft Irwin, California; Madigan AMC, Washington; Ft Carson, Colorado; Ft Hood, Texas; Ft Leonard wood, Missouri; Ft Polk, Louisiana; Ft Riley, Kansas; Ft Sill, Oklahoma; William Beaumont AMC, Texas; Ft Belvoir, Virginia; Ft Bragg, North Carolina; Ft Knox, Kentucky; Ft Benning, Georgia; Ft Campbell, Kentucky; and Ft Stewart, Georgia</p>			
<p>** (66C) Psychiatric Mental Health Nurse Duty Locations- This is a list of all the MTF's that have inpatient psychiatric services-please use this list when filling out preference statements: Korea-121 Gen Hospital; Tripler AMC, Hawaii; Landstuhl, Germany; Wuerzburg, Germany; Madigan AMC, Washington; Ft Hood, Texas; Ft Leonard wood, Missouri; William Beaumont AMC, Texas; Walter Reed AMC, D.C.; Ft Bragg, North Carolina; Dwight David Eisenhower AMC, Ft Gordon, Georgia; Ft Benning, Georgia; Ft Jackson, South Carolina and Ft Stewart, Georgia</p>			

Community Health Nursing Course Dates	
<p>6H-F9 STD/Other Communicable Disease Intervention Course (pre-requisite for the 6A-F5 Course): 8-13 Feb 04 24 Aug- 5 Sep 04</p>	<p>6A-F5 Principles of Military Preventive Medicine: 16 Feb- 16 Apr 04 6 Sep- 5 Nov 04</p>
<p>Contact MAJ (P) Agin at: agind@hoffman.army.mil. Please see your facility's Nursing Education Representative or nursing chain of command if you are interested in attending. Please note FY03 AOC/ASI Course dates are listed at https://www.perscomonline.army.mil/ophsdan/anc_profdevt.htm. Also note that 6H-F9 is now two phases. Phase 1 needs to be completed prior to Phase 2. For information visit the website at http://www.cs.amedd.army.mil/dphs/CHP/index.html</p>	

Assignment Opportunities

66H Lieutenants:

Assignment opportunities available for 66H Lieutenants include WBAMC El Paso, TX; 115th Field Hospital, Fort Polk, LA; Ft Sill, OK; Ft Riley, KS; 121 General Hospital, and Korea. Army Medical Center positions are available for winter/summer 2004. I can negotiate follow on assignments for officers that volunteer to select locations, i.e. Korea. If interested, please contact LTC Corulli, corullia@hoffman.army.mil

HOT! HOT! HOT!

66E – Please check our website at

https://www.perscomonline.army.mil/OPhsdan/anc_assignments.htm

66F – Ft. Hood, Summer 04

47th CSH, Ft. Lewis, WA, now.
Korea, Summer 2004.

Follow on assignments can be negotiated.

Other assignment opportunities are available for 66Fs and 66Es in a variety of locations. Please check our website at

https://www.perscomonline.army.mil/OPhsdan/anc_assignments.htm For these and other opportunities, please inquire to LTC Newman, newmanj@hoffman.army.mil.

Company Grade 66H, 66H8A and 66HM5

As we approach the Summer PCS cycle, I look forward to assisting you to meet your career goals and matching them with the needs of the ANC. There are great assignment opportunities that we can discuss together. I encourage you to seek the guidance from your chain of command also.

*****We must have 100% fill on all TO & E / FORSCOM and Korea slots.

We are looking for volunteers to deploy. There is a great need for your expertise for units deploying from Fort Bragg, Fort Riley, and Germany. Looking for officers to PCS to Fort Irwin NOW. We can negotiate your follow on assignment.

KOREA: We have openings NOW for 66H and 8A positions. We will also need a M5 for Winter FY2005 PCS cycle. We can negotiate your follow on assignment if you take one of the openings in Korea.

GERMANY: We have openings NOW in Heidelberg, 212th MASH, and Wuerzburg for 66Hs, 66H8As and M5s. If you are interested in a clinic position in Heidelberg, please let us know.

FORSCOM: We have openings NOW and Summer 2004 at the 67th CSH, 14th FH, 21st CSH, 115th CSH & 86th CSH.

66H: Opportunities exist at WBAMC, DDEAMC, Forts Carson, Leonard Wood, Bragg, Red Stone, Campbell, Rucker, Irwin

66H8A: Assignment opportunities are at Forts Carson, Leonard Wood, Sill, Hood, Polk, & Riley, WBAMC, and DDEAMC

66HM5: Assignment opportunities are at Fort Hood, Fort Benning, and Fort Stewart

*****Once we identified your assignment, I encourage you to write the Deputy Commander for Nursing/Chief Nurse to give the leadership a chance to get to know you and what some of your goals and objectives are.

DEPLOYMENTS: If you are due to re-deploy early next year and you are PCS vulnerable for summer 04, we can negotiate/discuss your next assignment and report date. If you are "PCS Vulnerable" for summer 2004, please give me a call or email me so we can discuss your next assignment.

Please call me or email gordonv@hoffman.army.mil.

HOT-HOT-HOT!!! CPT and MAJ 66H, 8A, M5 DIVISION NURSE Positions:

25th ID - Hawaii

3rd ID - 203rd FSB - Fort Benning

3rd ID - 703d MSB - Fort Stewart

4th ID - 64th FSB - Fort Carson

1st MED BDE - 566th ASMC - Fort Hood

1st ID - 101st FSB - Fort Riley (Deployed - Intratheater PCS)

1st AD - 125th FSB - Fort Riley

782nd Division slot @ Fort Bragg (must be jump qualified)

2nd ACR - 2d SPT SQDN - Fort Polk

10th MTN - 710th MSB - Fort Drum

2d ID - 296th FSB - Fort Lewis

62d Med Grp - 549th Med Co - Fort Lewis

1st ID - 299th MSB - Wuerzburg

1st AD - 501st FSB - Freidberg

1st AD - 47th FSB - Landstul

1st ID - 701st FSB - Wuerzburg (MUST FILL)

If you are interested in being a Division Nurse, please call LTC Gordon or MAJ Ahearne to discuss what this awesome and challenging position entails.

MAJ and CPT(P) 66H, 8A, M5 and all ranks 66P:

Summer 2004 job openings are posted please check the website at:

https://www.perscomonline.army.mil/ophsdan/anc_assignments.htm

FORSCOM: Due to current operation tempo all TOE positions are required to be filled at 100%. There are still a variety of critical TOE opportunities available both in FSTs and CSHs:

8A Opportunities

10th CSH Fort Carson

555th FST Fort Hood

31st CSH Fort Bliss

28th CSH Fort Bragg

86th CSH Fort Campbell

240th FST Fort Stewart

I am looking for someone to fill a 66H MAJ Slot at the 115th Field Hospital at Polk. I can negotiate a follow on assignment for officers that volunteer for select locations, (Fort Irwin and Fort Polk).

*******I have an immediate fill requirement for 66Ps at Fort Bliss and Korea.**

I am also looking for a Hem/Onc trained 66H MAJ for head nurse positions at Fort Bliss and Tripler.

Thank you all very much for your support!!!!

MAJ Ahearne: patrick.ahearne@us.army.mil

Office of the Chief, Army Nurse Corps	
Fort Sam Houston Office COL Deborah Gustke LTC Yolanda Ruiz-Isales MAJ Jeanne Larson AMEDD Center and School ATTN: MCCS-CN, Room 275 2250 Stanley Road Fort Sam Houston, TX 78234 210.221.6221/6659 DSN 471 Fax: 210.221.8360 yolanda.ruiz-isales@amedd.army.mil jeanne.larson@amedd.army.mil	Washington, DC Office LTC Kelly Wolgast Headquarters, DA Office of the Surgeon General 6011 5 th Street, Suite #1 Fort Belvoir, VA 22060-5596 703.806.3027 DSN 656 Fax: 703.806.3999 kelly.wolgast@belvoir.army.mil AN Website: http://armynursecorps.amedd.army.mil/ AN Branch PERSCOM: www.perscomonline.army.mil/ophsdan/default.htm

14th Annual Asia Pacific Military Medicine Conference

Co-Hosted by U.S. Army Pacific and the Australian Defence Force

The theme of the conference is

PROFESSIONAL MASTERY IN MILITARY HEALTH

Brisbane, Queensland Australia
[Hilton Brisbane Hotel](#)

9-14 May 2004

Abstract and poster submission deadline is **13 MARCH, 2004.**

The U.S. Army, Pacific and Australian Defence Force (ADF) are sponsoring the fourteenth annual Asia-Pacific Military Medicine Conference (APMMC XIV) in Brisbane, Australia at the Hilton Brisbane, 9-14 May 2004. The theme of this conference is "Professional Mastery in Military Health." Other topics include the military aspects of humanitarian deployments, preventive medicine, environmental medicine, infectious diseases, psychiatry, combat medicine, including medical strategies for low intensity battles, technological advances in telemedicine, and other military relevant medical topics. Over 30 foreign countries will be invited to present and exchange medical information. Interested U.S. military medical personnel (physicians, nurses, dentists, medical service corps, and veterinarians) are invited to attend. Continuing medical education and continuing nursing education units will be awarded for attendance at this conference.

We have posted APMMC XIV information / announcement / registration on the web at the following website:

<http://apmmc.org>

ALL REGISTRATIONS SHOULD BE MADE VIA THE WEB SITE

POC: COL Stephanie Marshall, Deputy Commander for Nursing, TAMC.

Email: stephanie.marshall@haw.tamc.amedd.army.mil or phone 808-433-5025.

Grant Camp 2004

The Resource Center of TSNRP Invites Applications

Grant Camp 2004 is a grant-writing workshop, presented in two phases, sponsored by the Resource Center of the TriService Nursing Research Program.

PHASE I **23 – 28 May 2004.** *Course presentations will cover Principles for Success; Fatal Flaws; Conceptual Framework; Developing Research Objectives; Research Design & Methodology; Measurement & Statistical Analysis; Timelines; Grantee Organizations; IRB Issues; Budgeting & Personnel; Packaging the Proposal; and much more. Sessions will consist of lectures, round-table discussions, and one-on-one consultations with faculty. RESEARCH PLAN required.*

PHASE II **19-20 August 2004.** Mock scientific review. Participants must submit a complete GRANT APPLICATION applying lessons learned in Phase I. Each participant will experience first-hand the scientific review process, serve as peer reviewer, and learn the key criteria used for scoring.

Eligibility

- ❖ All Active Duty, Reserve, & National Guard Nurse Corps Officers are eligible to apply. Target audience - novice or junior investigators with limited research experience.

Requirements

- ❖ Attendance at BOTH Phase I & Phase II of Grant Camp 2004.
Phase I will be in Bethesda, MD; Phase II is tentatively scheduled for San Diego, CA.
- ❖ Submit a written RESEARCH PLAN for Phase I and a GRANT APPLICATION for Phase II. Refer to <http://usuhs.mil/tsnrp/applying/submissionguidelines.html>. To navigate the website: Click on PHS 398 Forms, select Full Set of PHS 398 Forms, scroll down to Research Grants - Table of Contents, and then **Submit items A – G under RESEARCH PLAN.**

Submission Deadlines

- ❖ **5 April 2004.** Electronic copy of RESEARCH PLAN and application form must be received in the TSNRP office by 5:00 p.m. Eastern Time.
- ❖ **18 July 2004.** Electronic copy of revised and complete GRANT APPLICATION must be received in the TSNRP office by 5:00 p.m. Eastern Time. Refer to <http://usuhs.mil/tsnrp/applying/submissionguidelines.html>.

Notification

- ❖ **19 April 2004.** Notification of acceptance and further instructions will be sent to applicants via e-mail by 5:00 p.m. Eastern Time.

Disclaimer

- ❖ Attendance at Grant Camp does not guarantee funding of your research proposal.

Please address questions about Grant Camp 2004 to:

Maria Burcroff
Resource Center Coordinator
TriService Nursing Research Program
mburcroff@usuhs.mil
Telephone (301) 295-7064 Fax (301) 295-7052
www.usuhs.mil/tsnrp

AAACN Tri-Service Military Pre-Conference Registration

The Tri-Service Military Special Interest Group (SIG) is proud to offer you an exciting opportunity to attend the annual conference and meeting held in conjunction with the 29th annual conference of the **American Academy of Ambulatory Care Nursing (AAACN)**. Information regarding the conference is available through the AAACN National Office at 1-800-AMB-NURS or via the Internet at <http://www.aaacn.org>

The Tri-Service Military SIG will be held at the **Hyatt Regency Phoenix at Civic Plaza**. For room reservations, call 602-252-1234 or go on the Hyatt web site at www.hyatt.com. The Hyatt reserved a limited amount of rooms at government rate. They are also holding a block of rooms for AAACN attendees at the conference rate of \$179 plus tax. Alternate lodging is available in the area. (Fee includes conference materials, 6 continuing education credits, morning and afternoon beverage breaks, breakfast and lunch. You will receive a receipt when you sign in at the pre-conference, but you will not receive a confirmation notice.) *"Military Contributions to Forging New Partnerships and Championing Change."*

Conference Registration Form

(Form may be photocopied. Please Print)

Name: _____

Address: _____

Branch of Service: _____

Work Phone: _____

Home Phone: _____

E-mail: _____

Years of Ambulatory Care: _____

Area of Focus: _____

Name tag: _____

(Title/Credentials)

To register, complete this form and mail (postmarked NLT 8 Mar 2004) with payment to:

Major Tammy Doyle, USAF, NC
DoD Health Service Region 5
Building 6 Area B
2776 C Street Suite 200
Wright Patterson AFB, OH 45433-7401

Make checks payable to:

Tri-Service SIG Pre-conference

Advanced Registration: \$100

Registration at the Door: \$125

Please Direct Questions Regarding the Pre-Conference to COL Monica Secula @
monica.secula@amedd.army.mil