Commissioned Corps BULLETIN

Division of Commissioned Personnel • Program Support Center, DHHS

Vol. XVII, No. 9 **September 2003**

Surgeon General's Column

This month America will observe the second anniversary of the devastating September 11 terrorist attacks. Thousands of innocent people lost their lives while simply conducting routine business and travel.

As we remember the heroism of those who lost their lives, and the loved ones they left behind—of the valiant firefighters, Emergency Medical Services (EMS) personnel, and police officers who responded that day, and of our own Public Health Service Commissioned Corps officers who reacted to health needs in the aftermath of 9/11—we also look ahead to preventing similar disasters.

America is constantly under health threats, both from intentional terrorist threats and naturally occurring disasters—such as weather-related emergencies and emerging illnesses.

We must take an 'all hazards' approach to emergency preparedness, one that can handle anything—a weather-related emergency, or a shooting, or a terrorist incident. And we must be prepared at all levels: Federal, State, local—and in all disciplines: health, the military, law enforcement, science, research, education, and first responders.

Since 9/11, under the leadership of Secretary Thompson, the Department of Health and Human Services (HHS) has spent or requested $9.2 billion to prepare America for all-hazards response. We are investing that money in Project BioShield, a 10-year, $6 billion comprehensive effort to develop effective drugs and vaccines to protect against biological and chemical attack, on enhancing the National Pharmaceutical Stockpile, and on newer and safer smallpox and anthrax vaccines. HHS has also distributed $2.5 billion to States in grant funding which is the largest investment in our public health infrastructure, ever.

Secretary Thompson has developed a state-of-the-art command center down the hall from his office to track public health emergencies anywhere in the world, and provide up-to-the-minute information to local responders and the media.

In the spring, I rolled up my sleeve and was vaccinated against smallpox to show health care professionals and first responders the importance of being personally prepared. Senate Majority Leader Bill Frist of Tennessee, a doctor and a friend of mine, was also vaccinated. What's more, he received training to be a first responder. In case of a suspected smallpox emergency, Senator Frist is now prepared to administer the vaccine.

That is the type of outside-the-box thinking and flexibility we need. Our world today is not business as usual. It is a world where we *all* need to be prepared and flexible, no matter our expertise. That is why I am also working with groups that are not usually thought of as having a role to play in preparedness— including veterinarians, dentists, communications professionals, and medical educators.

You may wonder what a veterinarian has to do with homeland security. The reality is that the signs and symptoms of many disease agents that could cause great damage in the hands of a terrorist, such as foot and mouth disease, sheep and goat pox, and others, show up in *animals* first.

America is a huge nation, both in terms of population and physical size. Terrorists could strike anywhere, anytime. *Everyone* needs to be prepared. The reality of this is that today there will be no 'special forces' elite unit immediately available from the Federal government to contain a biological or chemical attack. Local EMS personnel, police, and fire units will be the first to respond. All disasters are local events.

Americans need to be prepared physically, mentally, and emotionally. Since September 11, we've been living in a state of elevated risk. The goal of terrorists extends beyond physical destruction, to instilling fear, anxiety, and depression in their perceived enemies.

Three *thousand* people lost their lives on September 11, but through those tragic events, more than 280 *million* people were traumatized. The stress of terrorism, war, and natural disasters can lead to psychological challenges. As you know, all traumatic events bring intense reactions. Many bring personal upheaval. One of our greatest challenges is to build Americans' mental and emotional resilience to manage that stress so that they can continue working, caring for their families, going to school, serving their communities, and living their lives.

Part of building that resiliency will be showing the American people that we have set up a homeland defense system that can truly protect us, and a medical system that is prepared to deal with any crisis.

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Surgeon General's Column

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To that end, the Federal government can provide guidance and coordination for local agencies, and can help develop surge capacity for our local hospitals and emergency providers. That is exactly what we are doing through such actions as the following:

- ***First Responder Initiative*** – President Bush has proposed a 10-fold increase i'n funds to enhance the capacity of America's local responders. Through joint planning, coordination, and increased information sharing, America's first responders can be trained and equipped under the First Responder Initiative to save lives in the event of a terrorist attack.
- ***MRC*** – The Medical Reserve Corps is the health component of President Bush's volunteer effort, USA Freedom Corps, and the one I lead as Surgeon General. MRC units, based on the local level, are made up of citizen volunteers—nurses, doctors, paramedics, and other health care professionals—who are trained to respond to health crises.
- ***NDMS*** – The National Disaster Medical System links government entities and private organizations to plan for treating the medical and health effects of peacetime disasters and to deal with possible military contingencies. The NDMS is critical to developing surge capacity in hospitals to enable them to respond effectively to disasters.
- ***MMRS*** – The Metropolitan Medical Response System provides the logistical support on the local level that will allow cities to respond immediately to any terrorist threat, before State and Federal assistance arrives.

As Public Health Service officers, we have a unique skill set that can be called upon to help America prepare for the possibility of terrorist attack and for other disasters.

I urge you to join the efforts now underway to be as prepared as you can possibly be—both personally and professionally. In so doing, we honor the memory and example of those who perished on September 11, 2001.

VADM Richard H. Carmona
Surgeon General

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Keeping You Informed

Entitlements/Allowances for Permanent Change of Station (if Qualified Under the Joint Federal Travel Regulations (JFTR))

CALL-TO-DUTY AND ACTIVE-DUTY OFFICERS:

(1) Travel and transportation for you and your dependents;

(2) Movement of your household goods (HHG) up to your specified weight allowance and rank;

(3) 90 days of storage for your HHG, if needed;

(4) Dislocation Allowance (DLA), if qualified; and

(5) Temporary Lodging Expense (TLE) for up to 10 days before or after you leave your current duty station (not for a house hunting trip).

RETIRED OFFICERS:

(1) Travel and transportation for you and your dependents;

(2) Movement of your household goods (HHG) up to your specified weight allowance and rank; and

(3) One (1) year of Non-Temporary Storage (NTS) from point of origin.

Please remember that officers must always contact their Agency's shipping officer before performing any type of Permanent Change of Station (PCS) move, including a personally prepared move, to avoid reimbursement complications. This is true for active-duty and retired officers.

Q&A on Travel

Q. Effective January 1, 2003, the flat rate per diem for travel became $85 per night for officers. What was the rate change for dependents, and where can I find this information in the JFTR?

A. The spouse and the officer's dependents who are 12 years of age and older receive 75 percent of the member rate if they travel on the same day as the member (other rules apply if travel occurs on separate days). Children under the age of 12 receive 50 percent of the member rate. This can be found in the JFTR, Chapter 2, Paragraph U2025, and Chapter 5, Section C, Paragraph U5210, B, 1 and 2.

Q. Recently, I performed a PCS from San Diego, CA, to the Washington, DC, area. When I turned in my travel forms for reimbursement of my PCS travel, the mileage I traveled was crossed out and a lower mileage amount was written in. Why am I not reimbursed for the miles I traveled?

A. When performing a PCS, a member is entitled to the 'official' distance between two duty stations. The official miles for those distances are listed in the Defense Table of Distances (DTOD) and are mandated for use in the JFTR. The Government is officially responsible for the distance you move between duty stations, but is not obligated to the route in which you travel. This can be found in the JFTR, Chapter 2, Paragraph U2020, A-1.

Annual Leave in Conjunction with Temporary Duty (TDY)

(1) TDY travel is to be used only for official purposes, and never as a means of providing Government-paid travel for personal reasons. Therefore, annual leave shall not be granted for use in conjunction with official travel if such use would give the appearance of impropriety. In general, a request for annual leave should be denied if the TDY is for a very short period, or if the proposed leave is substantially longer than the TDY assignment.

(2) When annual leave is taken in conjunction with TDY which is less than 30 consecutive days in duration, the number of days chargeable as annual leave is computed as follows: (Note: if the TDY is 30 days or longer, use the normal rules for computing leave, subject to the provisions of item 3, below.)

(a) Determine the number of calendar days that the officer **would have been unavailable** for duty at the permanent duty station (regardless of whether normal workdays or non-workdays) due to **official travel status** if the TDY had been completed without the use of leave, using available schedules and

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modes of transportation that best meet the needs of the Government.

(b) Determine the number of calendar days that the officer was **actually unavailable** for duty at the permanent duty station (regardless of whether normal workdays or non-workdays).

(c) The difference between the number of days determined in subparagraph (a) and the number determined in subparagraph (b) is the number of days chargeable to annual leave.

(3) When an officer on TDY is permitted for personal reasons to use a mode of travel other than the mode that the Government would normally select for purposes of the ordered travel, then all full days of travel in excess of the travel days, which would have occurred using the normal mode, are chargeable to annual leave.

If you have questions pertaining to your travel entitlement, check the 'Commissioned Corps Travel and Transportation Center' under 'Services' on the Division of Commissioned Personnel's Web site—http://dcp.psc.gov—or call or e-mail LCDR Ron Keats at 301-594-3376 / rkeats@psc.gov. □

Commissioned Corps Readiness Force

CCRF Deployment Roles

If you have not yet gone to the Commissioned Corps Readiness Force (CCRF) Web site and recorded a Deployment Role, you need to complete this immediately. We will no longer roster officers as simply a member of their respective category, but rather will place them on a rotation roster based on the role they will fill on a deployment. For example, if we need a 'Liaison', then we need an officer with a broad understanding of the capabilities of the Agencies/Operating Divisions in the Department, as well as someone who has completed the 'Liaison' training course. It is not helpful to just go to a list of officers broken down by category. Officers will be rostered in the immediate future in their ***role***, so please comply with this request.

CCRF Officers Immunize Army Personnel

In August, 16 CCRF officers assisted in the vaccination of 330 military and civilian personnel for smallpox. CCRF's support was needed because the area Army medical facilities are short staffed because personnel are deployed to the Middle East or are directly involved in the care of wounded soldiers at Walter Reed Army Medical Center. CCRF officers involved in this mission included physicians, nurses, one pharmacist, and one health educator. This was an excellent opportunity for CCRF's experienced smallpox vaccinators to teach other officers how to administer the vaccine and perform 'take checks.'

Officers who would like to learn more about smallpox are encouraged to visit—http://www.smallpox.army.mil. Also, Standard Form 600, "Chronological Record of Medical Care - Smallpox Vaccination Initial Note Page" is available at—http://www.smallpox.army.mil/media/pdf/Vacciniainitial3.pdf.

CCRF Officers Deploy with the U.S. Forestry Service

This summer, the U.S. Forestry Service (USFS) has been engaged in fighting wildfires concurrently in six states across the American West. The USFS, which employs a small number of environmental health officers and engineers, has been overwhelmed with issues such as the occupational health and respiratory protection of firefighters, the environmental well being of national forests and parks, and water/waste water problems. In addition, the USFS was engaged in performing water system surveys on 30 wells and pumps on public lands in northeastern Oregon. In the past, USFS had not been required to perform such surveys and therefore they were not adequately staffed for this task. However, since the 30 water systems all provide potable water to the public and are under the jurisdiction of the Safe Drinking Water Act, the need to survey them was imperative.

In July 2003, the USFS contacted CCRF and CCRF in turn asked the Chief Professional Officers (Environmental Health and Engineering) to identify officers with the requisite skills. In August 2003, one CCRF engineer and one environmental health officer were deployed to Oregon to perform these water system surveys. CCRF is pleased to be able to work with the USFS and hopes that this is the beginning of a new relationship between the USFS and the Public Health Service (PHS) Commissioned Corps.

CCRF Basics Course for Bureau of Prisons Members

CCRF offered the Basics Course to CCRF members on July 19-20 in Rockville, MD; August 4-8 in San Diego, CA; and August 18-22 in Butner, NC. Of the approximately 175 participants, most successfully completed the APTF and the basic online training modules. In general, the Basics Course includes the basic 12 core modules essential for deployment, daily fitness activities, Basic Life Support for Healthcare Providers (BLS), uniform wear inspections, and military courtesies. The Basics Course will be held in September in Anniston, AL, and is fully subscribed. For more information see—http://oep.osophs.dhhs.gov/ccrf/2003%20Training.htm.

Training with the American Red Cross

In May 2003, CCRF nurses deployed with the American Red Cross (ARC) to care for victims of the Midwest tornadoes in Missouri and Tennessee. This activity was predicated on a 1984 Memorandum of Understanding (MOU) between ARC and PHS. The MOU between the PHS and ARC and its local chapters established policies and procedures to facilitate joint emergency planning for disaster relief. The ARC has a long history in disaster response of helping people in their most vulnerable time. The ARC mission meshed perfectly with that of CCRF.

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Commissioned Corps Readiness Force

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The ARC was very impressed with the CCRF nurses who deployed, but identified ways in which CCRF officers could more quickly be incorporated into the ARC program. On July 22, ARC provided training to 19 CCRF nurses and 4 CCRF staff members. This training was a test of an ARC-suggested training program and was limited to CCRF nurses who live in the Washington, DC Metropolitan Area. Future training will be offered in various locations across the United States. CCFR hopes to include other categories in ARC missions as this partnership develops.

CCRF Welcomes New Staff

CCRF is very pleased to have two new staff members—LT John Mallos and LTJG Elizabeth Slawinski.

LT Mallos holds a B.S. degree in nursing from Oregon Health Science University and his clinical area of expertise is pediatrics/pediatric oncology. He has been in the PHS Commissioned Corps since 2000 and his last assignment was in the Navajo Area Indian Health Service at Tuba City Indian Medical Center. While in Tuba City, LT Mallos was the Lead Clinical Nurse on a 16-bed pediatric unit. He has been an active member of CCRF since being commissioned. Currently, he is a candidate for his M.S. degree in nursing at Northern Arizona University. LT Mallos is focusing his degree on both rural and public health nursing. Prior to entering the Corps, he was a law enforcement officer/detective in Southern California and was in the U.S. Coast Guard in both active-duty and reserve status.

LTJG Elizabeth (Betsy) Slawinski graduated with a B.S. degree in environmental health from Bowling Green State University in Ohio. Before graduating she was a Junior Commissioned Officer Student Training and Extern Program participant at the Navajo Area Indian Health Service, Fort Defiance Medical Center. LTJG Slawinski's first assignment since coming on active duty in June 2001 was a detail to the U.S. Coast Guard in Norfolk, VA. LTJG Slawinski has been an active member of CCRF since September 2001.

CCRF: The First 10 Years

CCRF will be 10 years old in 2004. CCRF is in the process of recording its history in a unified format. As such, we are requesting stories, photos, etc., from you to be included in the history. Of course, your work will be credited. We need your thoughts and remembrances related to your various missions. If you send photos, please provide a caption. This is your opportunity to 'preserve' your personal contribution to CCRF and to the history of the PHS Commissioned Corps. Please use the submission form posted on the CCRF Web site—http://oep.osophs.dhhs.gov/ccrf—or e-mail CDR Martinelli (to receive the submission form) at amartinelli@osophs.dhhs.gov.

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Flight School Training

Submitted by: CDR Jay Garrido

Under an interagency agreement, the Division of Immigration Health Services (DIHS) (within the Bureau of Primary Health Care, Health Resources and Services Administration) serves as the medical authority of the Bureau of Immigration and Customs Enforcement (ICE), formerly the Immigration and Naturalization Service (INS). The Division provides medical support for the law enforcement mission of ICE. Since becoming a part of the Department of Homeland Security, ICE has experienced an increased need to transport people in their custody to domestic and international destinations. Many of these missions require sophisticated medical support.

To meet this need, CAPT Gene Migliaccio, DIHS Director, negotiated an agreement with the U.S. Air Force to provide specialized training to nurses, nurse practitioners, and physician assistants for aeromedical evacuation. Only the best and the brightest are selected for this program. Upon completion, the candidates earn flight wings and the honor of being a member of an elite team of specialists who travel the world on special missions. In February 2003, I attended flight school at Brooks Air Force Base.

I was selected as the Program Manager for the DIHS Aeromedical Program and the first person from the Division to attend the U.S. Air Force Flight Nurse Aeromedical Evacuation Course. It sounded exciting, but at the same time intimidating. I graduated over 10 years ago and the thought of attending 30 days of intensive medical training that included physically demanding conditions made me wonder if they should have picked someone younger.

During the first days of the class, I spent a lot of time explaining the commissioned corps and the mission of the Public Health Service (PHS). There were 37 students in my class; all from the Air Force except one Navy officer and me. Strangely enough, people were not interacting with each other, but they all were interested in finding out who I was. I was selected as the overall class leader, responsible for ensuring that all the students were accountable 24/7. This added to my already moderate stress. The first test, a medical review, was tough. Two people failed. It was an eye opener to what the rest of the course would be like.

I was also to keep an eye out for the people who were having problems and try to help them. I took this opportunity to bring the group together. I organized meetings with the class and developed study groups to help classmates absorb the incredible amount of information that was being presented to us.

During the first week we studied altitude physiology, which taught us about the changes of gases in different altitudes. The best part of that section was the actual flight chamber, which took us up to 35,000 feet. During the climb we wore oxygen masks at 100 percent and when we reached 35,000 feet of altitude we were told to take off our mask and breathe the air until we developed three signs of hypoxia. Once we experienced three signs of hypoxia we immediately put our masks back on again at 100 percent oxygen. It was a bit scary, but fun.

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Flight School Training

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As the classes continued, we learned about the stresses of flight on the human body. Also included in our coursework was learning about medical equipment used in air evacuation and about the different aircraft we would be working in. We were tested on all aspects of the different types of aircraft as well as medical equipment. The pace of learning was incredibly fast. Then, as war began in Iraq, the class pace was stepped up even more! We participated on an actual live flight with simulated missions.

I encouraged the class by stating that we started together, and we would graduate together. Everyone was doing fine except for one person who told me he did not think he could pass this course and was in danger of washing out. I spent several hours trying to help him put all his issues into perspective, but it still did not look good.

During the next couple of weeks, I met several times with the director of the program and some faculty staff. They felt that they should pull this person out of class and send him back to his duty station. I requested that they give me an opportunity to work with him. I began to work with him on a daily basis. He was able to pass all his tests and everyone who started together graduated together!

My most treasured moment came at graduation when I was asked to pin the officer that I had helped, which was a great experience for me. He stood at attention and saluted and said that he would have never made it without me. At that time the entire class and faculty applauded as we returned to our section. At the end of graduation I was asked to accept an award for exceptional leadership, the first of its kind in the history of the flight school.

CDR Jay Garrido (right) received a special leadership award at the graduation ceremony of an intensive 30-day Flight Nurse Aeromedical Evacuation Course. He is the Aviation Medicine Consultant for the Division of Immigration Health Services.

I was honored to represent the PHS Commissioned Corps during this training, and honored that I was able to elevate PHS in the eyes of members of the U.S. Air Force. □

Subsequent to CDR Garrido's training, four additional Division of Immigration Health Services staff members completed the Flight Nurse Aeromedical Evacuation Course. (Pictured 3rd, 4th, 5th, and 6th from top left) LTJG James Ruddy, LTJG Adria Meyer-Alonzo, LT Victoria Vachon, and LT Ron Pinheiro pose with a cadre of flight instructors.

Call for Nominations for the 2004 AI/ANCOAC Honor Awards

The American Indian/Alaska Native Commissioned Officer Advisory Committee (AI/ANCOAC) is now accepting nominations for five different awards presented by the committee:

- Leadership Award
- Annie Dodge Wauneka Award
- Flag Officer Award
- Senior Officer Award
- Junior Officer Award

To be eligible, the nominee must be an American Indian/Alaska Native Public Health Service (PHS) Commissioned Corps officer who has been employed by the Federal Government for a minimum of 2 years during her or his current tour. The emphasis for nomination should be on sustained outstanding performance, a superior contribution to the field of their discipline, and evidence of dedication to the principles of the PHS mission and vision.

Please visit the AI/ANCOAC Web page at—www.aiancoac.freeservers.com—for more specific details regarding the selection criteria and instructions for completion of the nomination form.

The AI/ANCOAC awards co-chair must receive all nominations by the close of business on **April 1, 2004**.

If you have any questions or concerns, please contact:

LCDR Wil Darwin, Jr.
AI/ANCOAC Awards Co-Chair
Acoma-Canoncito-Laguna Service Unit
Pharmacy Department
P.O. Box 130
San Fidel, NM 87049

E-mail: wdarwin@abq.ihs.gov
Phone: 505-552-5393 MST
Fax: 505-552-5484

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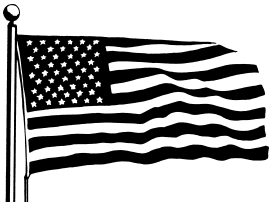

9/11 REMEMBERED

NIH Promotion Ceremony Held

Promotion ceremonies in Wilson Hall on July 18, 2003, honored 37 National Institutes of Health (NIH) Public Health Service (PHS) Commissioned Corps officers. RADM Richard G. Wyatt, the NIH representative to the Surgeon General's Policy Advisory Council, presided. RADM Kenneth P. Moritsugu, Deputy Surgeon General, gave the keynote remarks and officiated along with family members and coworkers in the placement of promotion boards for each officer.

RADM Wyatt emphasized the partnership of commissioned officers and civil servants in carrying out the complementing missions of NIH and PHS. "The mission of the NIH and the mission of the commissioned corps are and have been linked together for decades. The importance of the Corps at NIH and the commitment to officers here are unquestionable and not debatable," he noted.

"We are witnessing presently at NIH the efforts of our Director, Dr. Elias Zerhouni, in developing a road map to help guide research. Likewise, we are witnessing the unveiling of the Secretary's plan to transform the commissioned corps to meet the public health and emergency preparedness challenges it faces," RADM Wyatt told the audience of nearly 130 officers, family members, and friends, "It is our responsibility to work together to find ways to fit both challenge and mission together meaningfully. To do that, you will be key participants in developing solutions to these issues."

In his remarks, RADM Moritsugu added that the PHS Commissioned Corps is facing a period of exciting transition, "Through the transformation, our commissioned corps will increase in size, capability, and deployability, with an increased clinical focus. We will be part of that transformation, and through it, our Corps will be stronger, more robust, and more responsive to the public health needs of our Nation for the 21st century."

Officers honored were:

Nurse Officers: CAPT Sheryl Meyers, CDR Rosa Clark, CDR Melissa Law, CDR Colleen Lee, CDR Martha Marquesen, CDR Lucienne Nelson, CDR Susan Orsega, CDR Lois Young, LCDR Gettie Audain-Norwood, LCDR Michelle Bynum, LCDR Anissa Davis, LCDR Felicia Duffy, LCDR Leo Fitzpatrick, LCDR Barbara Fuller, LCDR Sandra Griffith, LCDR Lois Hunter, LCDR Angela Robinson, LT Tamika E. Allen, and LT Carol A. Corbie.

(Front row left to right) CAPT Mark Haines, CDR Colleen Lee, LCDR Gettie Audain-Norwood, LCDR Anissa Davis, LT Carol A. Corbie, RADM Kenneth Moritsugu, LT Tamika Allen, CDR Lois Young, LCDR Barbara Fuller, LCDR Lori Hunter, and CAPT Donald Mattison.
(Second row left to right) LCDR Gregory Langham, LCDR Sianat Kamal, LCDR Sandra Griffith, CDR Susan Orsega, CAPT Sharon Gershon, CDR Martha Marquesen, LCDR Leo Fitzpatrick, LCDR Angela Robinson, CDR Rosa Clark, CDR Mary McMaster, and CAPT Sheryl Meyers.

Medical Officers: CAPT Donald Mattison, CDR Mary McMaster, CDR Karen Near, and CDR Jose Serrano.

Research Officer Group: CAPT Crystal Mackall, CAPT Jeffery Miller, CAPT Michael Quon, CDR Lucinda England, and CDR Sharon Jackson.

Pharmacy Officers: CAPT Sharon Gershon, CAPT Michael Montello, and CDR Julie Rhie.

Veterinary Officers: CAPT Mark Haines and LCDR Gregory Langham.

Dental Officer: CDR James Schaeffer.

Scientist Officer: LCDR Martin Sanders.

Dietitian Officer: CAPT Maureen Leser.

Health Services Officer: LCDR Sianat Kamal.

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Retirements – August

Title / Name	*Agency / OPDIV / Program*
MEDICAL	
CAPTAIN	
Stephen M. Feinstone	FDA
Sander G. Genser	NIH
David J. Gordon	NIH
William R. Jarvis	CDC
Janine M. Jason	CDC
Thomas M. Kessler	IHS
Kenneth H. Kraemer	NIH
Dale N. Lawrence	NIH
Phillip I. Nieburg	CDC
Stanley L. Slater	NIH
Mark M. Vietti	IHS
Thomas A. Wehr	NIH
NURSE	
CAPTAIN	
Gary J. Kunz	BOP
Melva V. Owens	HRSA
Glenn A. Pruitt	BOP
ENGINEER	
CAPTAIN	
Terry L. Christensen	NIH
PHARMACY	
CAPTAIN	
John A. Becher	CDC
Robert O. Waudby	IHS
COMMANDER	
Michael F. Breckinridge	IHS

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Recent Calls to Active Duty

Title / Name — Agency / OPDIV / Program

MEDICAL

LIEUTENANT COMMANDER

Thomas M. Herndon — DHS
Kodiak, AK

David E. Katz — CDC
Jamaica Plain, MA

Michelle K. Leff — NIH
Baltimore, MD

Juan E. Palacio — DHS
Juneau, AK

LIEUTENANT

Chineta R. Eure — CDC
Atlanta, GA

Robert L. Gustofson — NIH
Bethesda, MD

Mark C. Janowski — CDC
San Diego, CA

Meredith S. Josephs — HRSA
Washington, DC

Norman C. Petty — IHS
Kodiak, AK

Robert V. Sigh — HRSA
Clearwater, SC

Michael C. Thigpen — CDC
Atlanta, GA

DENTAL

COMMANDER

Jan C. Colton — IHS
Pine Ridge, SD

LIEUTENANT

Jane A. Bleuel — IHS
Tuba City, AZ

Richard J. Kolanda — DHS
Clearwater, FL

Minh K. Lee — IHS
Cass Lake, MN

Linda K. Lovejoy — IHS
Fairbanks, AK

Brandy L. Wheeler — IHS
Dillingham, AK

NURSE

LIEUTENANT COMMANDER

Lori J. Austin-Hansberry — FDA
Rockville, MD

Diana S. Koltun — IHS
Santa Fe, NM

LIEUTENANT

Felecia A. Bailey — BOP
Petersburg, VA

Eric L. Campbell — BOP
Fort Worth, TX

Tzu-Ching Liu — IHS
Anchorage, AK

Gordon Quam — IHS
Albuquerque, NM

Barry C. Skelton — IHS
Anchorage, AK

Lawrence A. Wheeler — BOP
Rochester, MN

LIEUTENANT J.G.

Nicole M. Boulanger — IHS
Winslow, AZ

ENGINEER

LIEUTENANT

Nikhil A. Thakur — FDA
Rockville, MD

LIEUTENANT J.G.

Helena Attakai — IHS
Anchorage, AK

Darron Clark — IHS
Fort Defiance, AZ

Bradley S. Cunningham — FDA
Rockville, MD

SCIENTIST

LIEUTENANT

Karon Abe — CDC
Atlanta, GA

Linda Ahdieh-Grant — CDC
Atlanta, GA

Victor I. Balaban — CDC
Atlanta, GA

Michael E. King — CDC
Atlanta, GA

ENVIRONMENTAL HEALTH

LIEUTENANT J.G.

Derek R. Sakris — IHS
Bethel, AK

VETERINARY

LIEUTENANT

Zandra H. Duprey — CDC
Atlanta, GA

Kis L. Robertson — USDA
Beltsville, MD

PHARMACY

LIEUTENANT

Kari E. Barrett — IHS
Tahlequah, OK

Eliot M. Gaurkee — IHS
Gallup, NM

Terry Harrison — IHS
Sells, AZ

Gregory S. Hawkins — IHS
Hugo, OK

Gina A. Jorgenson — IHS
Anchorage, AK

Peter I. Juve — IHS
Winnebago, NE

Michael P. Kelly — IHS
Wellpinit, WA

Richardae C. Taylor — FDA
Rockville, MD

Judith B. Thompson — IHS
Anchorage, AK

THERAPY

LIEUTENANT J.G.

Douglas E. Henry — IHS
Phoenix, AZ

HEALTH SERVICES

LIEUTENANT

Kendrick Begay — IHS
Shiprock, NM

John J. Bucholtz — OS
Washington, DC

Paul R. Dewitt — IHS
Gallup, NM

David Dietz — HCFA
Baltimore, MD

Loretta B. Flaitz — IHS
Anchorage, AK

Linda K. Ford — BOP
Fort Worth, TX

Byron G. Henry — FDA
Atlanta, GA

Cecile M. Town — CDC
Albuquerque, NM

LIEUTENANT J.G.

Dorinda D. Ball — IHS
Parker, AZ

Christl D. Bonaparte — HRSA
San Diego, CA

Confidence M. Gbarayor — FDA
Rockville, MD

Elaine C. Wolff — OS
Washington, DC

ENSIGN

Sunee R. Danielson — IHS
Bethesda, MD

Mary Ellen Evans — IHS
Bethesda, MD

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Uniform Service Center

The Uniform Service Center of the District of Columbia Branch of the Commissioned Officers Association sells donated uniforms and uniform-related items at reasonable prices. It is located in the Park Building, 12420 Parklawn Drive, Room 1-46, Rockville, MD, and is open from 12 noon to 1 p.m. every Wednesday.

Please note: The service center provides sales of used uniforms and uniform-related items only to officers who can personally come to the shop—***items are not sold by phone and cannot be mailed to officers***.

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Some criticisms have been made about the current Commissioned Corps Personnel Manual (CCPM) Pamphlet No. 61, "Information on Uniforms" (which is available at—http://dcp.psc.gov—click on 'Publications'). The truth is, this pamphlet is a wonderful ***tool*** for the wearing of the Public Health Service (PHS) Commissioned Corps uniforms.

Many parts of the pamphlet are written in a way that allow each officer to interpret the correct wear of the uniform. In the future, this will change; the pamphlet will be revised and become more instructive and specific. Until that happens, each officer should read the uniform pamphlet realizing that 'uniformity' is the goal, and looking sharp and distinguished in the uniform is the ideal. Officers should not wear the PHS uniform in a way that is denigrating to themselves, the Corps, or the Agency/Operating Division/Program where they work.

Q. I am having trouble finding the Army pullover sweater. Where can I buy this sweater?

A. An excellent question. Many officers call because they are unable to locate this sweater, or they hear that the sweater is being discontinued. As of this date, there is no information leading us to believe that this uniform item has been or will be discontinued. The easiest way to purchase this sweater is through the Army clothing store online. You must register with the online Exchange service, then follow the prompts until you get to Army clothing. The URL is—http://thor.aafes.com/ics/default.asp?loc=home.asp.

Q. Can the blue windbreaker be worn with the Summer Khaki uniform? If so, what garrison cap is appropriate, blue or khaki?

A. Yes, the blue windbreaker is authorized for wear with the Summer Khaki uniform. Whether wearing the khaki or blue windbreaker, the appropriate cover would be either the khaki garrison cap, or the khaki combination cap made with the same material as the khaki uniform being worn. The authorized fabrics for the Summer Khaki are Certified Navy Twill (CNT) or the poly/wool blend.

Q: Is the female beret authorized for wear with the Summer Khaki or Working Khaki uniforms?

A. No, the female beret is *not* authorized for wear with the Summer Khaki or Working Khaki uniforms. This is a common mistake that officers make when wearing headgear. It is important to review CCPM Pamphlet No. 61, "Information on Uniforms," when you are unsure about the components authorized for wear with a specific uniform.

Q: Can officers wear the Army V-neck pullover and/or the Army cardigan sweater with the khaki uniform?

A. Remember there are two types of khaki uniforms, Summer Khaki and Working Khaki. The Summer Khaki is classified as a 'general purpose service uniform' and is worn for normal 'office' working conditions. The correct fabrics for this uniform are the Certified Navy Twill (CNT) and the poly/wool blend. Both the Army V-neck pullover and Army cardigan sweaters are authorized with this uniform (remember the cardigan is for use indoors only). The Working Khaki is classified a 'working uniform' and is worn in situations where other uniforms would be unsafe or become unduly soiled. The correct fabric for this uniform is the poly/cotton blend material. Currently, the Army V-neck pullover sweater is ***not*** authorized, but the Army cardigan sweater ***is*** authorized for wear with this uniform.

Q. I am not currently an active-duty officer, but remain in the system as an inactive officer. Are there times I might be able to wear my uniform? If so, where may I purchase the uniform components?

A. When an officer is 'inactive', the wearing of the uniform is not authorized except for occasions of ceremony and at gatherings of organizations consisting primarily of Uniformed Services members and former members. (See INSTRUCTION 1, Subchapter 26.3, Section H - 1, of the CCPM.) For those occasions where you may be authorized to wear the uniform, you should contact an authorized uniform sales company such as Navy Exchange or Lighthouse Uniforms online (Note: This is *not* an endorsement for either company)—http://www.navy-nex.com/ (or) http://www.lighthouseuniform.com/. Please be sure that anytime you wear the PHS uniform, it is worn correctly with the appropriate devices and rank, with pride, and that the occasion is appropriate for wear.

Q. Can you advise me on the correct way to wear the miniature medals, and if you have more than one of the same award, how is it worn with the miniatures?

A. MEN:

Miniature medals shall be worn with all Formal Dress and Dinner Dress uniforms. On the male officer's Formal Dress and Dinner Dress jackets, the holding bar of the ***lowest*** row of miniature medals shall be positioned 3 inches below the notch and centered on the lapel, parallel to the ground. Three or more miniature medals will be positioned starting at the inner edge of the lapel and extended beyond the lapel on the body of the jacket. When worn on the male officer's Blue Service or White Service coats, the holding bar of the ***lowest*** row of miniature medals is centered immediately above the left breast pocket.

WOMEN:

When worn on the jacket of the female officer's Formal Dress uniform or Dinner Dress uniform, the holding bar or the ***lowest*** row is worn in the same relative position as on the male's Dinner Dress jacket, down 1/3 of the distance from the shoulder seam to the coat hem. When worn on the female officer's Blue Service or White Service coats, the holding bar of the ***lowest*** row is centered immediately above the left pocket flap. Each row of miniatures shall be 2 1/4 inches long from top of ribbons to bottom of medals so that the bottom of each medal

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Q & A on Uniforms

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constitutes a horizontal line. Upper rows of medals shall be positioned so that these medals cover the ribbons of the medals below.

WHEN YOU HAVE MORE THAN ONE OF THE SAME AWARD:

As with other awards, when you have more than one of the same type of award, you place a gold star on the ribbon for your second through fifth award. When you receive this award a sixth time, you would replace the gold star with a silver star. The silver star represents five awards and the miniature medal represents the sixth award. Remember, in a Uniformed Service, silver is always higher than gold. (Note: There is a misprint in the current edition of CCPM Pamphlet No.61, "Information on Uniforms," in regard to stars placed on miniature medals. The correct size of the stars for the miniature medals is the 3/16 inch stars, *not* the 5/16 inch stars. This will be corrected in a future publication of CCPM Pamphlet No. 61.)

If you have questions about PHS uniforms, please e-mail LCDR Ron Keats at: rkeats@psc.gov.

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Reminder

Thrift Savings Plan 'Catch-Up Contributions'

Public Law 107-304 permits eligible Thrift Savings Plan (TSP) participants to make 'catch-up contributions' into their TSP accounts beginning in or after the year in which they turn age 50. Active-duty officers age 50 or older or who will become age 50 during calendar year 2003 are eligible.

Please see page 5 of the August 2003 issue of the *Commissioned Corps Bulletin* for more information.

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PHS Officer's Experience in Mozambique with STOP

Submitted by: CDR Bill Orman, Tuba City Regional Health Care Corporation, Tuba City, AZ

The Stop Transmission of Polio, or STOP program, supports the worldwide effort to eradicate polio. Polio eradication began following a World Health Assembly resolution in 1988, when Ministries of Health of all countries resolved to eradicate the disease. In partnership with Ministries of Health, this effort is led by the World Health Organization (WHO), UNICEF, and other key partners including Rotary International and the Centers for Disease Control and Prevention (CDC). Over the years, CDC has provided technical expertise to the polio initiative, especially in the areas of epidemiology, surveillance, and laboratory science. In 1998, CDC initiated the STOP team program with the objective of accelerating the progress of eradicating polio. The STOP program helps meet the critical need of placing skilled and motivated public health professionals in key field positions during this final phase of the eradication effort.

The success of the program is demonstrated by the dramatic decrease in the number of cases of paralytic polio from an estimated 350,000 per year at the start of the initiative in 1988, to less than 2,000 cases in 2002. Poliovirus circulation is now confined principally to seven remaining endemic countries. Large areas of the world have already been certified polio free, including the Americas, Europe, and the western Pacific.

Road to the Tsangano District in Tete Province, Mozambique.

A joint CDC/WHO project, STOP recruits, trains, and deploys teams into the field worldwide three times a year, on 3-month assignments. Individual projects and destinations vary depending on specific national needs. They are often rugged field assignments, focusing mainly on assisting with polio surveillance, immunization campaigns, and detecting and responding to polio cases. Other STOP members may lend technical assistance in capital cities in the area of data management and logistics. Recently STOP teams have also been trained in measles control strategies and have integrated measles activities into their assignments. There is really no 'typical' STOP assignment, but it is probably fair to state that all will involve significant

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PHS Officer's Experience in Mozambique with STOP

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challenges and hardship conditions, but also significant rewards for those with enthusiasm, flexibility, and creativity.

To date, 13 STOP teams have been deployed. Approximately 120 members of the Public Health Service (PHS) have participated, mostly from CDC. Non-PHS members and non-U.S. citizens are also eligible, providing they have the requisite health or epidemiology backgrounds. In STOP 13, the group I deployed with, there were three commissioned officers, several other CDC employees, and a total of 35 volunteers, many from other countries. Our country assignments were literally A to Z, with teams going to Angola, Chad, Congo, Ethiopia, Laos, Madagascar, Mozambique, Namibia, Niger, Pakistan, Sudan, and Zambia.

My own association with STOP began innocently enough when I opened my e-mail one morning in the spring of last year. An e-mail forwarded from CDC was marked priority and solicited volunteers, especially those able to speak either French or Portuguese, willing to undertake a 3-month hardship assignment unaccompanied by family. I had never heard of STOP, but the assignment sounded intriguing. I am a pediatrician in the Indian Health Service (IHS), and never had the chance to do any international work except some time spent in Latin America as a med student many years ago.

I discussed the possibility of participating with my supervisor, who gave me thumbs up, and I then called and interviewed with CDC. Assignments typically begin in September, January, and May, and I requested a May slot since that would correspond with the slowest time of year for our pediatric practice and put the least burden on my colleagues.

I received my country assignment to Mozambique in March of this year. Team members may state preferences for countries or areas, but are not given any guarantees. I speak Portuguese, so my assignment was based on language skills and WHO's determination of the need for assistance in that country. (Not all team members have foreign language skills, however, and some assignments are to English-speaking countries.)

Mozambique is a country of about 18 million people bordering the Indian Ocean in southern Africa. It achieved independence from Portugal in 1975, but then plunged into a horrific civil war that lasted almost 20 years and destroyed much of the country's infrastructure. A variety of natural disasters also afflicted the nation, including both devastating droughts and major floods. The result is one of the poorest nations on earth, with a per capita income of $210 per year, and an under age 5 childhood mortality rate of 197 per thousand live births. Despite these gloomy numbers, however, the country has achieved a fairly remarkable degree of political stability since 1993, and is generally felt to be making significant gains in all areas, including health.

A 'measles room' in Mozambique.

After a significant amount of planning, packing, and receiving immunizations, STOP 13 team members all traveled to CDC in Atlanta in early May for approximately a week of intensive orientation and training in polio and measles. We received many lectures, ranging from the art of high tech gene sequencing, to the imminently practical art of collecting, packing, and shipping stool samples. We also received many pounds of written materials, including the all important polio 'flip chart' in our countries' home languages—a compilation of written and visual aids to be used in the field for all aspects of polio training.

We learned basically that polio eradication involves two main strategies: immunization and surveillance. Clearly, high levels of immunity must be attained to interrupt poliovirus circulation. Perhaps less obvious, eradication also depends heavily on a sensitive detection system. As the disease becomes rarer, it becomes much more important to detect every remaining case. If a country has a poor health infrastructure to begin with, cases can be missed or underreported, resulting in false assessments of poliovirus existence and transmission.

New friendships were made in Atlanta, and for us field officers, it was fun to finally get to see the famed CDC. Time passed quickly, and then one morning training was over and it was off to the airport and Africa to get to work. My team of three arrived in Maputo, Mozambique, after about 30 hours of travel, for another week of country-specific orientation and training. While in the capital, we met our WHO supervisor and key members of the Ministry of Health, and began the long process of acclimating to a new language and culture.

In Maputo we received our final field assignments. One person would stay in Maputo and assist with data collection and coordination on a national level. Another would travel to the far northern coastal province of Cabo Delgado ("Ah, beautiful beaches," everyone commented.) And my assignment? The interior province of

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Tete, bordering Malawi, Zambia, and Zimbabwe, divided in half by the mighty Zambezi River. I asked everyone in Maputo what Tete was like, and the response was remarkably uniform—a pained expression on the face, a groan, and the comment, "Ah, Tete. Very hot. Very, very hot. Don't go there!" Since I am from Arizona and love the desert, I knew immediately that this was a match made in heaven for me!

After orientation, I flew approximately 800 miles north and met with my Mozambican counterpart at the provincial health department. I would be working closely with him for the next 2½ months. He was the provincial disease surveillance officer and had responsibility for polio surveillance. My task would be to help troubleshoot and improve the polio surveillance system in Tete Province, and to prepare my colleague to take over after my departure. (Provinces are similar to States in the USA, and districts approximately equivalent to counties.)

My initial impression of "Hot Tete"? I loved it, of course. A dry landscape dotted with huge baobab trees and tiny villages. The round village homes reminded me a bit of the hogans on the Navajo Reservation.

What was I up against? For the past 3 years, Tete Province had had the poorest record of surveillance in the whole country. Polio surveillance basically involves a system of detecting, reporting, and immediately investigating any case of acute flaccid paralysis (AFP) in a child. It is known from long experience gained early in the campaign that every country should have a minimal background level of non-polio paralytic illness, diseases such as Guillain-Barre and transverse myelitis. This level is expected to be at least 1 case per every 100,000 children under age 15 years, if surveillance is adequate. Many countries with good surveillance report numbers significantly higher than this. Tete, based on its population of 650,000 children, should report at least 6 or 7 cases a year. Instead, it had reported zero cases each year. My job was to find out why, and to do something about it within 2 months.

I quickly caught on to some of the obstacles. The province consists of 13 districts, some accessible only by 2 to 3 days travel on dirt roads. Plus, there is virtually no communications network outside the provincial capital. There are only eight physicians for the whole province, all but two in the capital city, and only one pediatrician. I met with the provincial health director who smiled and welcomed me to Tete, then informed me that while they had a vehicle I could use, there was no money for either fuel or a driver.

"Good morning, doctor!" from students in a school in the Zumbo District.

Fortunately, our excellent training in Atlanta had prepared me for all these contingencies. I remembered vividly some of the last words spoken as we prepared for departure from CDC: "Now remember, STOP team, flexibility and a sense of humor will be your best friends." Truer words were never spoken, and with some creative planning, obstacles were overcome, and I was ready to start my project.

With a stroke of luck, I was also able to arrange housing with a French UNICEF physician in Tete who had been in country since their civil war days, and was able to offer invaluable advice about the country and province.

I began making almost daily trips out to the districts, to visit rural hospitals, health centers, and tiny, often one-man health posts. With my counterpart, we would discuss polio and paralysis with health staff, and try to learn why no cases were being reported. Using the flip chart, I gave dozens of talks about polio and flaccid paralysis, tailoring the talk to my particular audience. Sometimes we would travel and return to the capital the same day. On trips to remote areas, we would sometimes be out all week.

Why no case reports? Trends quickly emerged. Many parents didn't bring their kids to the health centers, but went to curandeiros, or traditional healers, instead. They would eventually be seen at a health center, but often months after the onset of their illness. Review of registers revealed that in some centers virtually every pediatric illness was classified as either malaria or measles. Clinicians were seeing cases of paralysis, but classifying them as cerebral malaria and not reporting them as AFP cases. Diagnostic testing was virtually nonexistent in many areas, even for diseases such as meningitis. Worried about the validity of their diagnoses, I explained that we would need reports on *all* cases of acute paralysis, even malaria or meningitis cases. Clinicians nodded in agreement and promised they would start reporting. To increase awareness in the community, we also spoke with a curandeiro association, with the Red Cross, and other non-government organizations with links to the rural areas, and with churches as well. Basically I talked about polio with anyone who would listen, even to people in the market.

We met with our share of obstacles. One day, I had two separate vehicles break down. I got to watch a local mechanic try to fix an oil leak with a sledge hammer and a chisel, his only

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PHS Officer's Experience in Mozambique with STOP

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tools. It didn't work. Washed out roads were common. Communication was a constant problem. I could not begin to count the number of times we would arrive at a site only to find that the key staff members were not present. "They are out on an immunization brigade," is a phrase etched in my memory. Checking ahead of time was virtually impossible, as phones were nonexistent, and radios rare. Food on the road was interesting, too—my colleague offered to let me try a local delicacy, smoked field mouse! I smiled and thanked him, but declined.

As my project began to wind down, case reports were climbing, and we had investigated nine cases, which included collecting stool samples required for laboratory detection of poliovirus. Problems remained, but I could sense that many here had started to share my enthusiasm and excitement. I would always emphasize that we were all participating in what are hopefully the final years of this campaign to rid the world of an awful scourge. I was hopeful that with the groundwork I had laid, the project would sustain itself after my departure.

As an aside, I also was able to see pediatric diseases that are now rare in the United States—many hundreds of measles cases (I was consulted on control measures in several outbreaks); neonatal tetanus; falciparum malaria; kwashiorkor and marasmus.

I was also humbled by the comparison between my working conditions at home in the IHS, and the conditions under which these clinicians struggled. Labs whose only equipment was an old microscope. 'Pharmacies' with bare shelves. 'OB wards' consisting of a single rusty bed in an otherwise empty room. No power, no phone. Hit or miss transportation.

On an up note, I was able to see parts of Mozambique that are virtually unvisited by outsiders. I was often treated as a special guest and had many special moments. On one occasion at a rural clinic, the headmaster of an adjacent school saw me and emptied the whole school to wait outside and wish me "Bom dia, doctor!" (Good morning, doctor.)

I would recommend STOP to anyone with a strong interest in children's health. Enthusiasm, flexibility, and a sense of humor are definite requirements. A pretty high tolerance level for bugs, dirt, and long, bumpy roads certainly helps, too! For me, this has been one of the definite highlights of my PHS career, and I am extremely grateful to the staff at CDC, my home hospital, and my supervisor and colleagues at Tuba City for allowing me to participate.

Travel is on official Government travel orders, and CDC pays a per diem and covers job-related expenses. Salary is not paid by CDC except for CDC employees.

For more information on STOP and how to apply, check the CDC Web site at: www.cdc.gov/nip/global.

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Recent Deaths

Note: To report the death of a retired officer or an annuitant to the Division of Commissioned Personnel (DCP), please phone 1-800-638-8744.

The deaths of the following retired officers were recently reported to DCP:

Title / Name	*Date*
MEDICAL	
CAPTAIN	
Kazumi Kasuga	07/31/03
Richard Yocum	07/28/03
LIEUTENANT J.G.	
Lester I. Leonard	07/30/03
NURSE	
COMMANDER	
Jenine H. Rakich	07/18/03
Lawrence A. Stavish	07/14/03
Mildred O. Walter	07/02/03
ENGINEER	
CAPTAIN	
F. A. Flohrschutz, Jr.	08/01/03

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