From the Corps Chief...

Shipmates,

I want to directly address this year’s special pay plan and our way forward in Navy Medicine. As we have already entered a new era of global strategic competition, Navy Medicine has been forced to evolve in order to ensure readiness in anticipation of tomorrow’s challenges. I said I wanted to speak directly, and so by “challenges”, I mean up to and including “near-peer warfare.” The Secretary of the Navy is charged with many difficult decisions regarding how to execute the budget provided to him by Congress, which includes ensuring that our Medical Force posture is appropriate for its mission. Strategic decisions in a world of limited resources (billets, funding, etc.) require risk-tolerance decisions across the Navy. I can tell you that your leadership strongly advocated the risks to force-manning and our record of superior performance over the past twenty years was appreciated throughout the decision-making process. That being said, we now have our mission and it is our responsibility to execute it. Sailors and Marines still depend on us.

Primary changes resulted in increases to several critical wartime specialties and decreases in several overmanned specialties. Simply put, it is difficult to justify offering retention bonuses when percent manning is significantly higher than the operational need. This pay plan is not reflective of the value of any specialty or individual, but simply the manning.

As physicians, we look at data and use it to anticipate problems on the horizon. Pre-medical students may consider it indicative of future pay and GME opportunity. Our stance in the Medical Corps has been clear and firm. The complex interdependencies amongst residency training programs, coupled with civilian market-drivers and unique aspects of operational medicine, makes the recruitment and medical training of Navy Physicians via HPSP, HSCP, and USU essential to our ability to provide high quality doctors to the Fleet.

GME and Special Pay plans are reviewed yearly, and the GME Planning for next year begins next month. The diversity of our Navy and Marine Corps mission, requires a diverse force and our strength comes from our ability to quickly adapt as the mission requires. It truly takes all of us to succeed and there are still GME opportunities for every specialty. Physician specialists who are interested in making Navy Medicine a career, but currently serving in a specialty that is significantly overmanned, should understand that special-pays decisions are linked to recruiting, manning, and retention. As these changes are intended to drive change in the status quo, it is reasonable to expect that this year’s plan is not indicative of what future plans may be.

As for our Corps, we have already begun re-orienting several operational medical officer positions to be in-line with future needs requirements. This will in-turn drive future GME and Special Pays decision to ensure we have the force we need to support the warfighter.

I am immensely proud to serve amongst the finest physicians of the highest character. These times are certainly challenging, and new leaders will emerge amongst us. Those who are able to see past the storms of today, and help navigate us towards where we need to be tomorrow will truly be serving the Sailors and Marines to whom we are dedicated.

- JLH
Transition from Active Component to Reserve Component

Some of you may be considering a transition to the Reserve Component (RC) now or in the future. Service in the Reserve Component provides an opportunity for you to continue to serve while in civilian practice. This article should give you an overview of the current organization of Navy Reserve Medicine and review Active Component (AC) to RC transition process. First, I think it is essential to understand and acknowledge why the reserve component exists. The mission statement of the Navy Reserves clearly outlines this concept:

- **The mission of the Navy Reserve is to provide strategic depth and deliver operational capabilities to the Navy and Marine Corps team and Joint forces, in times of peace or war.**

- **“Navy Reservists seamlessly support and actively aid that mission, all while continuing to lead their own independent lives in the civilian world.”**

The need for reservists to be recalled to active duty varies depending on current events and peacetime requirements. Just last year, we had an increase in the number of Navy Reserve medical officers recalled to active duty for contingency operations as over 50 reserve medical officers will be mobilized to active from July 2019 to August 2020 which is higher than the previous year.

**Overview of organization/billets:**
In Navy Medicine, there are currently about 650 billets for medical corps officers in the reserve component in units supporting the Navy and Marine Corps. The units assigned to Marine Corps Forces Reserves are similar to active components with elements within all the major commands - MLG, MAW, MARDIV, and FHG. Naval aviation, NECC/Naval Construction Force, and Special Forces, etc. also have reserve billets. Currently, there are billets for about 40 Flight Surgeons and 8 Undersea Medicine Officers. For the surface Navy, there are a few billets at the component command level, but compared to active elements, few, if any, billets currently assigned to shipboard platforms although that could change.

Up until very recently, BSO 18 (BUMED) reserve commands were organized into 4 Expeditionary Medical Units (EMFs), 6 Operational Health Support Units (OHSUs) and 2 Forward Deployed Preventive Medicine Units (FDPMUs.) Traditionally, the OHSUs reported directly to the Navy MTFs, then to the regions (NME and NMW) while EMFs reported directly to BUMED. With the DHA /Navy Medicine transition, over the next 12-18 months, the organization will change but the concept remains in place. The details of the types of units are still being sorted out but could include units such as those attached to TAH (hospital ship) platforms or readiness/mobilization support units based at accession sites.

The current billet authorizations are based on the traditional structure. Accession to the reserves currently de-

(Continued on page 3)
pends on the need for billets based on this conventional structure. The demand and emphasis lie with some of the critical shortage specialties that are used for mobilization, such as general surgery, emergency medicine, orthopedic surgery, internal medicine/critical care, anesthesiology, psychiatry, and aviation medicine. For some specialties, there are only a very few RC billets: i.e., pediatrics, ENT, dermatology, and gastroenterology. Some communities are fully staffed or over-manned: i.e., plastic surgery, OB-Gyn, ENT, radiology, neurology, etc. Realize that this organizational structure will be changing, and the demand for certain specialties may be changing also.

Training Options:
If you have plans to complete your time on active duty and have been accepted to an accredited ACGME residency/fellowship in one of the critical shortage specialties, the Training in Medical Specialties (TMS) program may be an option to consider. The program provides a monthly stipend during residency/fellowship and allows a flex option to receive your drill/credit for some of your time in training. In return, you agree to serve two years for every year in the TMS program. The TMS program allows an option to participate without receiving a stipend, and that program comes with a 3-year commitment. Depending on funding availability, there are a few reserve medical officers that are selected to participate in the flight surgery or undersea medicine training programs and serve in those billets in the RC.

Transition process:
The Career Transition Office (CTO) at Navy Personnel Command (PERS-9) is available to assist with options for transition to the reserves. Reserve Component specialty leaders are also a good source of information. The contact info for CTO and a list of RC specialty leaders are on the BUMED Medical Corps Page under the Reserve section. After CTO determines if there are available positions based on specialty, they will coordinate with Centralized Credentialing and Privileging Department (CCPD) to perform a credentials pre-screening. This process involves confirmation of current privileges in the JCCQAS system and verification of current clinical activity in that specialty. Then CTO will then coordinate with local reserve centers for processing.

Benefits:
A significant advantage of service in the reserve component is the option to purchase Tricare Reserve Select insurance. This plan may provide a better choice than can be available for purchase by civilian practices. Retention Bonuses (RB) are available for some critical specialties in the reserves, and those bonuses currently range from $20,000 to $75,000 depending on the specialty. Currently, for any active duty service period longer than 30 days, you are eligible for Incentive Pay (IP) at the 1-year rate and Board Certification Pay (BCP) based on your specialty and current incentive pay plan. Reserve retirement benefits for the traditional retirement plans are available at age 60 for those that have at least 20 years of qualifying service. The benefit is based on the number of days of service on active duty and reserve drill periods. Another benefit that is often mentioned is the networking and camaraderie among other professionals that serve in reserves.

As mentioned in a previous column, the Navy Reserves includes very accomplished clinicians and academic leaders in various medical specialties. This provides the Navy with the strategic depth specified in the mission statement by offering some additional capacity and capabilities that may not otherwise be readily available. The reserves can provide an excellent opportunity to continue your military service while continuing to practice in the civilian sector.

I’m Just a Bill(et)...
CDR Melissa Austin, Plans and Policy

There are a handful of questions I have been asked repeatedly over the course of my dwindling tenure as Plans and Policy Officer, and I would like to tackle one of them for this newsletter. We have physicians in places (and in numbers) that do not always seem to make sense from a business case or clinical perspective (particularly with the enhanced emphasis on KSAs), and many a forward-thinking physician has proposed better use of those resources only to have their recommendation summarily rejected. Some of this seeming irrationality can be explained by the way manpower requirements are developed, so let me summarize that process (cue the “I’m Just a Bill” song from Schoolhouse Rock).

Requirements are defined by Joint Defense Planning Guidance, which is based largely on Operational Plans (OPLAN) and Joint Capability Integration Development System (JCIDS) estimates. This is the mechanism by which the Combatant Commanders (COCOM) define the most likely operational requirements, requirements that are then meted out to the individual services based on capabilities. The services, in turn, execute their Title 10 authority to man, train, and equip personnel to meet those COCOM requirements. Big Navy uses Required Operational Capabilities (ROC) and the Projected Operational Environment (POE) to establish the appropriate manpower distribution, and BUMED uses the oft-misunderstood Medical Manpower All Corps Requirements Estimator (MEDMACRE) to translate ROC and POE into number and flavor of medical department billets, ultimately generating a billet file that defines what we need and where it needs to be. In a perfect world, there would be one appropriately qualified body for each billet. In the real world, however, it becomes a delicate dance of doing the
Fresh Whole Blood Transfusion in the

2D Marine Division

CDR J. G. Kotora, MC, USN 
2nd Marine Division Surgeon

Combat produces human casualties. This tenant is as old as warfare itself. Throughout history, military medical providers have invested entire careers in search of training, education, and technology that reduces combat morbidity and mortality to the lowest extent possible. Combat mortality is largely a factor of logistics and resources. The most capable militaries deploy the best-trained, most experienced healthcare providers into austere settings. Equipped with the latest surgical and resuscitative technology, these field hospitals are capable of delivering unprecedented survival rates. If a casualty makes it to a Role Two facility alive, he or she has a ninety percent chance of survival. (Goldberg, 2014)

Making it to a Role-Two alive is the major challenge, and the biggest area of interest among tactical commanders. Ninety percent of combat trauma patients die in the prehospital arena, and the overwhelming majority succumb to exsanguinating hemorrhage. (Kotwal RS, 2011) Hence, the military needs a resuscitation asset that is safe, effective and capable of deploying in the prehospital setting to bridge the gap between care at the Point-of-Injury and forward surgical care. Enter the practice of Fresh Whole Blood transfusion (FWBT).

Fresh Whole Blood is not a novel concept, and has been utilized in warfare for centuries. However, it has recently become an en vogue practice among combat arms medical communities. Recently, the 2d Marine Division deployed to Marine Corps Air-Ground Combat Center (MCAGCC) to conduct the largest Marine Corps exercise in thirty years—the MAGTF Warfighting Exercise (MWX). MWX pitted 8,700 2D Division Marines against a peer adversary composed of U.S. and British forces for six-plus weeks. The goal of the exercise was to sharpen the basic combat skills required against peer adversaries in a displaced environment, and without the sophisticated technology and communication systems the Marine Corps has previously relied heavily on. A large portion of the medical footprint of MWX centered on the practice of FWBT.

The medical planning for MWX quickly exposed the gaps and risks involved in such an evolution. The casualty count exceeded the surgical facilities’ ability to deliver timely, effective surgical resuscitation. Moreover, the lack of air superiority prevented air CASEVAC transport off the battlefield to waiting Role-Two facilities. There were simply too many casualties and no effective way to move them. Faced with the grim possibility of a mass fatality event, rather than a mass-casualty event, the Division began training General Medical Officers and Hospital Corpsmen in collection and transfusion of fresh whole blood (FWB). FWBT could serve as a temporizing measure to resuscitate bleeding casualties, restore perfusion, and potentially afford seriously injured warfighters the time required to reach a Role-Two.

Although it may seem complex on the surface, the practice of FWBT is relatively simple and extremely safe, so long as the protocol is strictly adhered to. Both the Joint Trauma System (JTS) and the Committee on Tactical Combat Casualty Care (CoTCCC) have clinical practice guidelines for the collection and transfusion of FWB. (JTS, 2018) (Butler F, 2019) The process begins with identification and designation of a blood-donor pool within a unit. A blood drive is conducted, with heavy emphasis on service members with Type O blood. After blood is collected for donation, it is tested and confirmed to ensure it is truly Type O and free of infectious disease. A list of eligible donors is sent to the unit Medical Officer, and the list is reviewed with the Division Surgeon and the FWBT Program Director. At the conclusion of this meeting, the unit’s FWBT-approved roster is generated and certified. Personnel on the roster are identified as potential donors and are given a donor card to carry with them in combat. In the event FWBT is required, the unit Medical Officer or Hospital Corpsmen requests support from the unit’s operational leadership. A designated donor from the list is called up, and a unit of blood is collected from the donor after a brief donation questionnaire is completed. The collected unit is then transfused to the casualty to restore blood volume and perfusion. The empty blood bag and donor card are sent with the casualty to the next echelon of care to facilitate testing of donor blood, identification of any transfusion reactions, and documentation of the actual transfusion.

Some have questioned the safety of this practice, and have cited concerns of transfusion reactions or transmission of infectious disease. These risks are offset by meticulous adherence to the protocol and the pre-deployment testing and certification of the unit-donor roster. While it is impossible to completely prevent the possibility of transmission of recently-acquired diseases, it is important to understand the gravity of the situation and the reason this practice exists. FWBT constitutes a “last option” for casualties who have a reasonable chance at survival, are in hemorrhagic shock, and lack access to surgical resuscitation inside a field hospital. Many have asked, “Does it work?” Army Ranger medics within the 75th Ranger Regi-

(Continued on page 9)
In January 2020, Lieutenant Jonny Kim, of Los Angeles, Calif., made history as part of the first NASA class to graduate under the Artemis-lunar exploration program. The former Navy SEAL-turned Navy physician also holds the distinction as the first Korean-American astronaut in history and is in the running to become the first American physician to land on the moon and first person to embark on a mission to Mars.

For over 60 years, Navy physicians like Kim have played vital roles for NASA serving as key advisors, scientists, medical monitors, and—beginning in 1965—astronauts. In June of that year, CAPT Joseph Kerwin of Oak Park, Ill., became the first Navy physician chosen for NASA's nascent scientist-astronaut program.

In 1972, when NASA’s lunar program was coming to a close, Kerwin was selected as a scientist-pilot for Skylab, the first American space station and a platform for studying habitability in a gravity-free environment.

When Skylab launched in May 1973, Kerwin earned the distinction as the first American physician in space. He and fellow crewmembers Charles Conrad and Paul Weitz spent a total of 672 hours and 49 minutes aboard the Skylab station and 3 hours and 58 minutes conducting extra-vehicular activities (EVA) to repair the damage the station suffered in orbit. As the crew’s only physician Kerwin was also responsible for operating what could be called the first orbiting medical clinic. Equipped with an advanced medical kit called the In-Flight Medical Support System (IFMSS), Kerwin was equipped to manage minor injuries and illnesses and stabilize major problems should they arise. He later recalled, “I had intravenous fluids, drugs, a minor surgery kit for suturing, hemostasis, and I had a fundamental lab capability. I could even do cardiopulmonary resuscitation if it were necessary.” Fortunately, other than a few headaches, a dislocated finger and one case of fluid in the middle ear due to pressure change the Skylab crew proved quite healthy.

As the Skylab mission segued into the Space Shuttle program, six Navy physicians followed Kerwin into space as both mission-specialists and pilots.

CAPT Sonny “Manny” Carter, Jr. of Brunswick, Ga., was selected by NASA in June 1985 after a career as a flight surgeon-pilot with more than 3,000 flying hours and 160 carrier landings. He served aboard STS-33 (Discovery) in 1989 where he logged 120 hours in space.

CAPT Charles Brady, Jr., of Pinehurst, N.C., was flight surgeon who served with the Blue Angels Demonstration team. Selected by NASA in March 1992, Brady later served aboard STS Columbia (20 June to 7 July 1996), then the longest space shuttle mission and the first to combine “full microgravity studies and a comprehensive life sciences investigation.”

CAPT Jerry Linenger of Eastpointe, Mich., was a Naval Academy graduate (Class of 1977) and flight surgeon. Selected by NASA in August 1992, Linenger later took part in STS-64 (Discovery) in September 1994. In 1997, Linenger flew aboard STS-81 (Atlantis) on a mission to the Russian Space Station Mir. He spent 132 days, four hours and one minute in the space station setting (what was then) the record for the longest duration by an American in Space. Linenger retired from NASA in 1998.

CAPT Laurel Blair Salton Clark of Racine, Wisc., was a Navy undersea medical officer and flight surgeon selected by NASA in April 1996. From 1997 to 2000, Clark served in NASA’s Astronaut Office Payloads/Habitability Branch. Clark was one of two Navy physicians killed on 1 February 2003, when the space shuttle Columbia disintegrated 16 minutes prior to entry.

CAPT David Brown of Arlington, Va., was a flight surgeon and pilot selected by NASA in 1996. Soon after he became the first pilot qualified to fly the NASA T-38 aircraft. Brown was one of two Navy physicians killed on 1 February 2003, when the space shuttle Columbia disintegrated 16 minutes prior to entry.

CAPT Lee Morin of Manchester, N.H., was a Navy undersea medical officer and flight surgeon selected by NASA in August 1996. Morin served aboard STS-110 (Atlantis) in 2002 where he logged more than 259 hours in space and 14 hours of extravehicular activity (EVA).
Medical Corps Career Progression

Intent: The Navy Medical Corps Officer career path will deliberately develop the clinical, operational, and leadership skillsets required to lead Navy Medicine in positions of progressively increasing scope and responsibility.

Expectations: Officers who are competitive for promotion will have accrued both the operational and clinical experience necessary to serve in billets that are commensurate with the next rank.

### Recommended Medical and Professional Development Path

<table>
<thead>
<tr>
<th>INTENT</th>
<th>EXECUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Selection for residency</td>
<td>- Board certification</td>
</tr>
</tbody>
</table>

### Recommended High Reliability Organization (HRO) and Culture of Safety Developmental Training Opportunities

<table>
<thead>
<tr>
<th>Pre-commissioning Officer Development School (ODS)</th>
<th>Residency and Operational Schoolhouse Training</th>
<th>Basic Readiness Officer Course (BROC)</th>
<th>Advanced Readiness Officer Course (AROC)</th>
<th>Quality and Safety Leadership Academy (QSLA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Junior OMO Tour</td>
<td>- Senior OMO Tour</td>
<td>- Executive OMO Tour</td>
<td>- Senior Executive Tour</td>
<td></td>
</tr>
<tr>
<td>Surface Physician</td>
<td>Ship or Group SMO</td>
<td>LHA/LHD/CVN SMO</td>
<td>TYCOM/Fleet Surgeon Division/Group/Wing San</td>
<td></td>
</tr>
<tr>
<td>Marine Battalion Surgeon</td>
<td>Regimental Sgn or Group FS</td>
<td>Group UMO</td>
<td>Senior HQ/PERS</td>
<td></td>
</tr>
<tr>
<td>Flight Surgeon (FS)</td>
<td>Senior FS/UMO</td>
<td>GHE/HQ/PERS Staff</td>
<td>Senior GHE Billet</td>
<td></td>
</tr>
<tr>
<td>Undersea Medical Officer (UMO)</td>
<td>GHE Staff Officer</td>
<td>CATF Surgeon</td>
<td>Alternative Senior Billet</td>
<td></td>
</tr>
<tr>
<td>FST/MedN Specialty Staff</td>
<td>Chief Medical Officer (CMO)</td>
<td>Executive Officer (CMO)</td>
<td>Large NMRTC CMO</td>
<td></td>
</tr>
<tr>
<td>Resident Fellow</td>
<td>Director/Large Department Head</td>
<td>Director</td>
<td>Large NMRTC CMO</td>
<td></td>
</tr>
<tr>
<td>Junior Staff Physician</td>
<td>Assistant Program Director</td>
<td>Assistant Specialty Leader</td>
<td>Large NMRTC CMO</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program Director</td>
<td>Speciality Leader</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DIO/GME Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>XO/ICO</td>
<td></td>
</tr>
</tbody>
</table>

**Flag Track**

- CCOOM Surgeon
- PACEFLT Surgeon
- FLTFOR Surgeon
- MEF Surgeon
- MARFOR Surgeon
- Deputy TMO
- Senior HQ Director
- MEDCEN Director

**Abbreviation Legend**

- FST - Fleet Surgical Team
- CCOOM - Clinical Global Health Officer
- PACEFLT - Pacific Fleet Surgeon
- FLTFOR - Fleet Forces Surgeon
- MEF - Marine Expeditionary Force
- MARFOR - Marine Forces Reserve
- TMO - The Medical Officer
- MedN - Medical Administrative Officer

### Operational Medical Officer (OMO) Billets

Junior and Senior OMO Billets are equated as career progression. They are foundational tours that develop the operational competency necessary to serve as an Executive OMO. Typical reporting senior is below the Flag Level.

Executive OMO Billets are positions with strategic responsibility including the operations of subordinate OMO units and typically report to a Flag Officer.

Senior Executive Medical Officers are selected by the Corps Chief's Office.

---

The New Medical Corps Career Progression Slide - What Does It Mean to You?

By CAPT Joel Schofer, Deputy Medical Corps Chief

Navy Medicine has been undergoing a lot of change. We have a new Surgeon General, a new Corps Chief, and a renewed focus on readiness.

With these changes come a new career progression and path for the Medical Corps (MC) Officer. Let’s take a look at the new model and discuss some of the ways it will impact you as your career progresses. We’ll start at the top of the slide and work our way down, translating it into action items for every MC Officer.

**Intent and Expectations**

What should a MC Officer note in this section? To be competitive for promotion, you need to have been operational AND clinical. The days of camping at Military Treatment Facilities (MTFs) are over. Everyone needs to be operationally relevant, and this is consistent with the most recent changes to the O6 promotion board precept. It can be with the Surface Force, Fleet Marine Force (FMF), Undersea, Air, Special Operations, Joint environment, Expeditionary Combat Command, or any other operational setting you find yourself in. It doesn’t matter how or in what setting, but everyone needs to be operationally relevant.

**Action** – Deliberately develop your operational relevance.

Recommended Medical and Professional Development Path

Very simply, this spells out your educational pathway. Completing residency and becoming board certified is not a new concept or path for the MC Officer. What is new, though, is the expectation that everyone will serve in an operational setting by the time they are up for promotion to O5 and in a more senior operational role before they are up for O6. The concept of everyone becoming an Operational Medical Officer (OMO) is explained in detail at the bottom of the slide.

In addition to serving as an OMO, the expectation is that those who want to
serve in more senior roles will complete Joint Professional Military Education Levels I and II (JPME I/II) and obtain formal management or leadership training, such as a Master’s in Business Administration or similar degree.

**Action** - **Start JPME I now** if you haven’t already, and develop a strategy and timeline with your mentors to obtain more senior education.

**High Reliability Organization Training**

The new SG is a huge proponent of high reliability, and Navy Medicine is constantly striving to adopt the principles of a High Reliability Organization (HRO). Many of the classes mentioned on the career path slide are undergoing modifications and updates to incorporate high reliability education.

**Action** - Attend or complete the listed HRO courses.

**Example Assignments**

The example assignments are divided into Fleet and Navy Medicine Readiness and Training Command/Unit (NMRTC/U) positions. They are also stratified according to the typical ranks at which they would occur. These are general guidelines and variability will certainly occur, so be flexible. For example, we know that it takes a minimum of seven years to become a Neurosurgeon, so their path will vary. Other specialties that require longer training are in a similar situation. As a result of this, we are going to ask each Specialty Leader to take this generic career path and modify it for their own specialty.

Another takeaway from this portion of the slide is to alternate between operational assignments and NMRTC/U assignments where you are serving primarily in a clinical role, likely at an MTF. Time at the MTF will allow you to solidify your individual clinical skills and contribute to our Graduate Medical Education mission. After that tour, return to the operational setting in a more senior role. Rinse and repeat this pattern as your career progresses.

**Action** - Print the career path slide and get a red and black pen. In black circle the jobs, roles, and courses you’ve already done. In red circle ones you’d like to do. When it is time for your next set of orders, jump from realm where you currently are (Fleet or NMRTC/U) to the other and aim for one of the positions to the right that you circled in red.

**An Example – My Career Path**

Just to visualize the way we are encouraging you to use the career path slide, let’s take a look at my career path. I circled the things I’ve done in black, and the things I’d like to do in red.

As a 19 year O6, I have a lot of black ink, but there are some red circles to the right indicating the things I’d like to do. As the Deputy, I am currently in a senior headquarters role toward the right end of the Fleet portion. Most likely, my next career move will be to obtain JPME II or enter Executive Medicine as an Executive Officer (XO) because completing an XO and Commanding Officer (CO) tour is mandatory before I can compete for the more senior leadership roles. Use a similar analysis of where you’ve been (black ink) and where you want to go (red ink) to come up with options for your next career move.

**Summary**

The new MC career path should serve as the basic framework around which you structure your career. A quick summary of the actions you should take include:

- Deliberately develop your operational relevance.
- **Start JPME I now** if you haven’t already, and develop a strategy and timeline with your mentors to obtain more senior education.
- Attend or complete the listed HRO courses.
- Circle the jobs, roles, and courses you’ve already done in black. Circle ones you’d like to do in red. When it is time for your next set of orders, jump from realm where you currently are (Fleet or NMRTC/U) to the other and aim for one of the positions to the right that you circled in red.
Anthony Keller is the newly named Medical Corps Career Planner, relieving CAPT Will Beckman who has assumed the role of Head of Navy GME. CAPT Keller is a cardiologist who, prior to his arrival at BUMED, served as the Director of Medical Services (DMS) at Naval Medical Readiness and Training Command, San Diego since December 2016.

A graduate of the University of California at Riverside, Dr. Keller earned his medical doctorate from the Uniformed Services University in 2001. After completing an internship in Internal Medicine at NMC Portsmouth, he trained as a Naval Flight Surgeon and was stationed with Fleet Air Reconnaissance Squadron One in Whidbey Island, Washington from 2003 through 2005. He then completed his residency in Internal Medicine in 2007 and fellowship in Cardiovascular Diseases in 2010 at Naval Medical Center San Diego.

Dr. Keller has served as a staff cardiologist in San Diego since completing his fellowship in 2010. He was very active in undergraduate and graduate medical education. He is a former associate program director for the Internal Medicine Residency, and served as core faculty in the cardiology fellowship. He served as the site director for the Uniformed Services University’s Internal Medicine Clerkship at Naval Medical Center San Diego from 2011 through 2015.

In 2011, he deployed in support of Operation Enduring Freedom to the NATO Role III Multinational Medical Unit in Kandahar, Afghanistan where he served as a staff hospitalist and Director for Medical Services.

CAPT Keller served as head of the internal medicine clinic at NMC San Diego from 2013-2014. In 2015, he was elected President of the Medical Staff at NMC San Diego prior to “fleeting up” as DMS. He is a Clinical Associate Professor of Medicine at the Uniformed Services University, a diplomate of the American Board of Internal Medicine in Internal Medicine and Cardiovascular Diseases, and a fellow of the American College of Cardiology. He has several research presentations and publications. His military awards include the Meritorious Service Medal, Naval Commendation Medal, and numerous operational and unit awards.

I am indebted to a number of incredible mentors I have had along the way, and hope to pay it forward in my new role. Please don’t hesitate to reach out to me at Anthony.w.keller8.mil@mail.mil or call me at (703)681-8937 with questions, comments, concerns. Finally, it is my experience that a dose of humor is a great salve; please know that my door is always open for a good anecdote or joke.
As long as armed conflict continues to be an instrument of national power, human beings will be at risk of combat trauma. The options to treat the wounded are a matter of logistical proficiency. Getting the right resources to the right casualty at the right time yields the desired results of surviving to hospital discharge. Casualties at the point-of-wounding need resuscitation more than any other intervention, and fresh whole blood is the preferred resuscitation fluid. This practice has tremendous merit and affords battlefield casualties the best chance at survival. Some may consider FWBT taboo or dangerous; however, the same argument was previously made for the use of limb arterial tourniquets. The work of the 2d Marine Division demonstrated how a Division-sized force can effectively manage serious combat trauma while awaiting transfer to the next echelon of care. Most important, the Division’s FWBT program offered its warfighters a sense of reassurance and perhaps encouraged them to fight harder. Knowing that their brothers-in-arms were equipped with this capability offered them a sense of solace, and allowed them unbridled access to the warrior ethos.

References
Congratulations to the next generation of Navy Physician Leaders!

CAPT Michael McGinnis
    Force Surgeon
    US Pacific Fleet

CAPT Kevin Brown
    Fleet Surgeon
    US Fleet Forces

CAPT Peter Woodson
    Force Surgeon
    US Naval Forces Europe-Africa/Sixth Fleet

CAPT Richard Knittig
    Force Surgeon
    US Second Fleet

CAPT Gregory Thier
    Force Surgeon
    Naval Surface Force Pacific

CAPT Laurence Kuhn
    Force Surgeon
    Naval Air Force Atlantic

CAPT Robert Walter
    Force Surgeon
    Submarine Force Atlantic

CAPT Lanny Littlejohn
    Force Surgeon
    Navy Special Warfare Command

CAPT Michael Swanson
    Deputy Medical Officer of the
    Marine Corps

CAPT Brendan Drew
    Force Surgeon
    I Marine Expeditionary Force

CAPT Ewell Hollis
    Force Surgeon
    II Marine Expeditionary Force

CAPT John Rotruck
    Force Surgeon
    III Marine Expeditionary Force

CAPT Melanie Merrick
    Commanding Officer, NATO
    Role III, Kandahar (Spring)

CAPT Saira Aslam
    Chief of Staff
    Fort Belvoir Community Hospital

CDR Travis Deaton
    Force Surgeon
    1st Marine Division

CDR Emily Crossman
    Force Surgeon
    2nd Marine Division

CDR Peter Cole
    Force Surgeon
    3rd Marine Division

CDR Debra Buckland-Coffey
    Force Surgeon
    1st Marine Logistics Group

CDR Michael Barry
    Force Surgeon
    2nd Marine Logistics Group

CDR Andrew Branham
    Force Surgeon
    1st Marine Aviation Wing

CDR Janet West
    Force Surgeon
    2nd Marine Aviation Wing

(Continued from page 9)

Pages 9–10 of FY21

The following sentence is brand new:

Excellence in operational support settings should receive special consideration as Navy Medicine shifts greater focus to readiness and operational support.

Which brings me back to...

KEY MESSAGE – Navy Medicine is increasing its focus on fleet/FMF/operational support. Everyone needs to be operationally relevant to promote to O6.

Here is some more brand new stuff in bold:

Best and fully qualified officers for the rank of captain will be those with proven leadership experience who have demonstrated experience and expertise across the spectrum of military medicine, especially inclusive of operational experience and operational platforms. With Navy Medicine’s renewed focus on operational support and readiness, our future leaders must have shown leadership excellence in those activities.

MUST have shown. That’s a strong statement!

The Bottom Line

KEY MESSAGE – Navy Medicine is increasing its focus on fleet/FMF/operational support. Everyone needs to be operationally relevant to promote to O6.

Read that again, people:

With Navy Medicine’s renewed focus on operational support and readiness, our future leaders must have shown leadership excellence in those activities.
CAPT Kimberly Davis earned her undergraduate degree through the University of Texas and Medical Doctorate at USUHS. She completed an Ophthalmology residency at NMCS D and, after staff and department head tours, was selected for Full-Time Out-Service Glaucoma Fellowship at UCLA. Upon her return, she deployed with USNS MERCY in 2008 and became increasingly involved in GME, as both the NMC San Diego Transitional Year Program Director and Intern Specialty Leader. She then served as the Director of Public Health Services and Director of Surgical Services at NMC Portsmouth. She screened and slated to serve as the XO of NHC Hawaii and then the CO of NHC Annapolis. In addition, she earned her MBA and holds FACS and FACHE distinction. CAPT Davis is currently serving in her first post-command tour as the 4th Fleet Surgeon and was asked to share some of her insights into Navy Medicine with us…

With so much time invested in your surgical craft, how did you come to the decision to pursue executive leadership?

For as long as I can remember, I wanted to be a surgeon. As I explored options, I found that ophthalmology had a certain magic to it. Maybe it is the precision required, combo of clinical and surgical solutions, and the impact on quality of life for patients. There was never a deliberate decision on my part to step away from surgical practice. Leadership roles gradually required more and more of my time. Working with Rotators of all types as well as transferring skills to our ophthalmology residents was something I really enjoyed as a Chief resident and junior staff. The advertisement for NMCD TY PD caught my interest. Our success was the result of an amazing team, Jason Heaton, Rich Green, Michelle Valdez, and Erin Quiko to name a few. Impressive interns, like Andy Cronin, helped us update the curriculum and prepare Junior Officers for operational tours. Managing a subspecialty service while managing two dozen residents a year made me feel like I had 2 full time jobs and the balance was tough, but I felt validated and received joy in the group accomplishments. Once moving into more complex director roles, executive leadership reduced clinical time to 1 day a week. With my CO tour, time was tighter at ½ day a week and then 1 day a month as CO. For many of you working as highly skilled, full-time clinicians, that probably makes you cringe. I truly believe what I do now matters and know it is critically important that we have physician executives helping lead and shape our enterprise.

After your CO tour, what advice would you give to officers beginning to take on Department/Director roles?

Oh, there is lots of advice I’d give my prior self:
- Find a Senior Enlisted mentor
- Know yourself and bloom where you are planted
- Speak up and participate when you have a seat at the table
- Get and stay audit ready
- Learn from awards and promotion board experience - know how to write well, mentor, and advocate for your people
- Leadership communication is multidirectional – across, up, and down
- Everyone has something to teach you; don’t let personality get in the way of the message
- Lead by walking around; it’s fun, builds relationships, and you’ll see 1st hand what is going on
- Don’t rush to the next best thing, but gain the skills and be ready when opportunity knocks

What aspects of your junior officer experiences were most helpful during your senior leadership tours?

You know, everyone has such a unique path. I will highlight 2 areas. The first is my experience with GME. As a Program Director, I learned about ACGME and training the next generation of Navy Physicians. It was a career highlight to welcome them into our system in July from diverse backgrounds and to produce well-rounded Medical Officers ready to continue residency training or represent Navy Medicine in support of the line the following June. It also gave me the opportunity to meet and learn from subspecialists across the command and our civilian counterparts. This dove-tailed into the Specialty Leader role where I distinctly remember RADM Nathan (as MC Chief) highlighting the big picture and anticipated changes for Navy Medicine. As a member of Medical Education Policy Council (MEPC), I understood for the first time the complexity of the long range training plan for desired end strength.

The second key experience I would like to highlight is early participation with promotion boards and command awards boards. If you have yet to do so, participation is important for you to understand the rules of the game to best support those you are entrusted to serve through powerful verbiage in fitness reports and awards as well as record management and career development.

As you work with Line leadership on the highest levels, what aspects of your career helped prepare you the most?

Here is my infomercial... If you have yet to do so, consider signing up for Joint Professional Military Education (JIME-I) as soon as possible. I waited to do so until starting my CO tour - way too late. Required training for our line counterparts, these classes lay the foundation for understanding our history, policy, and strategy. There are a variety of course formats to fit every schedule. Warning: it is A LOT of reading and writing. Training, such as the Navy Senior Leader Seminar and Command Leadership School, also helped, as well as operational experiences including Pacific Partnership, RIMPAC, and wargame table tops.
Can you talk to us a little bit about raising a family while balancing the demands of your professional career?

We make time for what we prioritize. Best advice I can give is to choose a partner wisely and to openly discuss personal and professional goals. Stay committed to relationships and take time to grow with your spouse and kids. I married my high school sweetheart when I started medical school 27 years ago. Together, we have raised four children ages 23 to 15. Our first was born during my 4th year of medical school, 2nd as a GMO, 3rd during residency, and 4th 6 weeks before heading cross country to begin fellowship. My husband has supported the family as a full-time stay-at-home dad and we’ve moved 11 times. The toughest part was frequent school moves for our kids, but the upside is they appreciate the cultural diversity and make friends easily.

Were you always expecting career past 20 years?

OK, this response requires full disclosure. As the daughter of a Navy OB/GYN with two uncles who served as Navy Physicians and with my only brother as a Navy physician, I think I was definitely brain-washed at a young age. It’s hard to be a 21 year old kid trying to decide your career path. I was proud of my dad and he had just come back to Active Duty after being an activated Reservist in Desert Shield/Storm. I remember being introduced to RDML Robert Halder in 1991 when I was applying to medical schools and thinking it was so cool that an ophthalmologist could be in charge of such an impressive facility (dream job). Knowing I wanted to serve beyond 4 years, I chose USUHS over the HPSP scholarship. My commitment came and went and now we find ourselves here 27 ½ years later, looking forward to the next Navy adventure. The Navy has been good to us. No regrets.

As many medical officers will be forced to make career/life decisions during these uncertain times, what advice would you give?

Concur that these are uncertain times and when there is uncertainty, emotion comes into play. Force yourself look at things objectively and avoid the rumor mill. My recommendation is to reflect on why you joined the Navy. What contributions have you made? Is there anything else you would like to see or do while serving? Do you understand the why behind the MHS transition? Do you understand the nidus behind divesting certain areas and investing in others? Are you willing to adapt to help your Navy remain a player on the world stage? If so, we need your help. Continue to raise your hand and give those entrusted to your care and leadership the best you have.

What did you find most rewarding as a CO as a Senior Operational Leader?

The day I took command, RDML Anne Swap was spot on when she said, “Kim, it is all about the people.” As a CO of a smaller command, our Triad was afforded the opportunity to really get to know the team. The things I found most rewarding were the investments we made in the development of our people, joint partnerships, and innovation such as tele-health. Supporting the accession, pre-med/dental mentorship, and commission of the Brigade of Midshipmen were also incredible opportunities.

As an operational leader, I am enjoying learning from ‘Line-leadership’ to see first hand how topics such as Strategy and War, Joint Maritime Operations, and Theater Security and Decision Making come together to shape our mission and plans in the SOUTHCOM AOR and 4th FLEET. Observing the goodness of the 2019 USNS COMFORT Mission first-hand was hugely rewarding and current efforts with the Center for Naval Analysis and peers to improve survivability in distributed maritime operations are exciting.

What do you expect the challenges to be for future Senior Leaders?

Successful future senior leaders will need to be agile, creative thinkers who understand both the MTF and operational worlds and can find effective synergy through collaboration with joint, interagency, NGO, and partner nation entities. While understanding our history, we need to be willing to try different approaches to enhance our integrated contributions to force lethality and effective health care, all while ensuring fiscal responsibility. That’s a tall order.

Anything else?

I will leave you with one of my favorite quotes: “In 5 years, you will be the same person you are today except for the books you read and the people you meet.” Continue a quest of life-long learning and get to know your fascinating Shipmates.

(Junior Officer Spotlight, Continued from page 2)
best we can to get as close as we can with the resources we have.

Manpower requirements are hard and fast, at least until the operational requirement changes, and this can result in having more providers present than is justified by workload, or gaps in places where there is workload to support provider presence. Given our focus on skills sustainment and readiness, it can appear contradictory to knowingly send someone to a place where they cannot maintain their skills when there are facilities that have more than enough workload to sustain additional providers. At the end of the day, we are here to support operational requirements, and those must take precedence, even when it comes at a cost of skills decrement. As the KSAs mature, however, the hope is that we will be able to better define what constitutes appropriate skills sustainment and to develop strategies to facilitate it.

I want to close by saying that it has been an honor and a privilege to have served the Medical Corps as its Plans and Policy Officer. For the aspiring leaders in our ranks, it’s a job that I highly recommend. To everyone, thank you for all that you have done, for your continuing service as we navigate these heavy seas, and for all that you will do in the future. Having interacted with so many of you over the last 20 months, I know that Naval Medicine is in the finest of hands.