“Get down!” “Incoming!” “Shots fired. Take cover!”

I heard the blasts right over my head. I knew I should move to the bunker or the ditch, but I was just so tired and had lived through so many mortars being fired at us. Instead, I rolled out of my cot and put my vest over my head and hoped for the best. Seven rockets had been launched at us that night. Fortunately, our troops only sustained minor shrapnel injuries. It was just another typical night in Afghanistan. We had been sent overseas with a specialty group of Green Berets to perform VSOs (Village Stabilizing Operations) in an attempt to restore peace and order to the parts of the world ravaged by violence and terror. It was a dangerous place to be, but I wanted to be there and had been trained to go – although the experience would change my life forever.

continued on page 2
A Sergeant’s Story

continued from page 1

Being Deployed

It was very hot in Afghanistan, especially in the summer. It was about 130 degrees every day. The heat was so intense that the water in the water tanks became so hot that we couldn’t use it until nighttime. We only showered a few times per week and those had to be less than 5 minutes. We got care packages from home with wet wipes in them – we used those a lot. We had port-a-johns, but we couldn’t use those during the day because it was too hot inside them. We wore full, long-sleeve shirts and pants and carried 30-50 pound packs with us. We had a couple guys pass out related to heat exhaustion, but we got breaks and lots of water – we had to have camelbacks. We were trained how to manage the heat.

When in Iraq, we had 13 men living in a 10-man tent. We had air conditioning in the summer and we finally got running water toward the end of our deployment. We got very little sleep, so we drank lots of energy drinks and coffee. Some guys would smoke cigarettes or chew tobacco in order to stay awake, too. We’d sleep for a few hours and then just keep going in our attempt to bring stability to that area.

I developed some great relationships with my fellow soldiers. My platoon brothers were awesome. One guy in particular, John*, became my good buddy and roommate. John and I shared a lot of great stories and good times. Often, I looked up to John and gained a lot of support and strength from guys like him.

The Afghan Years

When we arrived in Afghanistan in 2012 for the VSO missions, our assignment was to work with Afghan soldiers and offer military support to their Army, who were fighting the Taliban. We helped train the Afghan soldiers and teach them basic training and effective military strategies. We gave them food, water, and supplies. We helped secure the villages by building fences so the women and children living in the area would feel safe and be able to go out and play. Taliban would attack Afghan civilians as they were trying to rebuild their villages. The workers would often have to stop building, engage in a firefight, and then return to rebuilding.

We would do recons overnight. We slept outside in ditches 4-5 nights at a time, getting 3-4 hours of sleep. We all took turns doing guard shifts throughout the night. We had to do a “stand-to” every morning, meaning we had to wake up an hour before dawn to get prepped and debriefed for the day. That was a dangerous time of day; we were most likely to get attacked at dawn.

* Name changed.
The terrain was treacherous and filled with the enemies in hiding. They were always waiting to ambush and were shooting at us all the time. The Army has technology to disarm improvised explosive devices (IEDs), so most of them didn’t explode near us. However, one time an IED exploded near an M-ATV (large truck) I was driving. It hit some members of my platoon, leaving several injured (some permanently).

Another time, some of our guys were heading back to base late at night when they came under enemy fire. One of the rounds caught one of the Green Berets in the head. He was on life support for several days, which gave his family time to fly to Afghanistan in order to say goodbye. I had to clean the vehicle, removing brain and skull fragments from the interior. It was really tough and something I never wanted to do again.

Not long after, something happened that I wasn’t prepared for. It was a dark and quiet night. Some of our platoon members were returning to the base from doing patrols. Their truck was almost back to the base when the Taliban shot from a recoilless rifle at the truck. A round of gunfire went through the vehicle. I was already back at the base and got called down to medical to help because one of our own had been killed in the ambush. I, and two of my soldiers, headed to the medical tent knowing we would have to carry a body. But when I got there, I wasn’t prepared for what I saw. It was my roommate and best buddy, John, who had been shot. Blood was everywhere. One of John’s legs had been blown completely off, severing an artery. He had numerous gunshot wounds, and three of his fingers were missing. An Afghan interpreter had been in the truck as well. Both John and our interpreter lost their lives that day. I had to tell my soldiers that John was dead. We all knew and loved him. I was grief stricken and heartbroken to have to put the American flag over the body of my friend. A Green Beret, two medics, and I carried John’s casket into the back of a Humvee that would take his body to an airplane to fly him home. As we slowly walked with the flag-draped casket, all of the soldiers— including those from all countries working with us—stood up and saluted our fallen comrade. I put John’s body in the back of the Humvee, and that was the last time I ever saw my buddy. John was 30 years old, a great soldier, a good friend, and now a fallen hero.

Back at Fort Stewart, where we were stationed state-side, we have tree service memorials. There are over 400 trees in the “Warriors Walk” to memorialize the fallen soldiers since the start of the War on Terror. We had a tree service memorial for John. The Generals were there. His wife, daughter, and son were there too. His daughter was crying; his son was only 6 years old. The hardest part of that service was walking up to his family, looking at those precious children, and shaking the hand of that little boy, knowing they would grow up without their father. Watching that little boy cry, knowing that he would never see his father again, was one of the hardest things I’ve ever experienced.

Returning to Civilian Life

My body hurts now. My hearing is gone. I was supposed to wear earplugs in the field, but if I put them in, I couldn’t hear to give commands, which I needed to do for my men.

My back hurts now. I’ve aged more quickly than other people who haven’t experienced similar kinds of things. It was hard to come back to the states. Every time I go under an overpass, I imagine there might be people up there in a position where they can attack or ambush me. It’s always in the back of my mind. If I hear a crack or loud noise, I immediately start scanning, wondering where it’s coming from. It doesn’t last too long. It’s real quick, but I’m just constantly looking, thinking, and wondering.

I don’t like to talk about some of the things I’ve experienced. It’s hard to lose close friends and be in constant danger. I don’t like thinking about it. I don’t like people to talk to me or ask me “understand,” especially if they haven’t been there or haven’t

A Salute to the Armed Forces, Veterans, and AMSN Military Members

Welcome to our special military-themed issue of MedSurg Matters! The purpose of this expanded issue is to recognize and thank those who are serving or have served in the Armed Forces. We aim to better describe the service of military nurses and to raise awareness of what our active duty and Veteran patients may have experienced as a result of their service to the United States. Some of the articles are very real and graphic, but will give nurses a better understanding of what Veteran patients may have experienced and how it could affect their health. We’ve included articles explaining post-traumatic stress disorder (PTSD), the Joining Forces Initiative, careers of military nurses, the ROTC program, and the experiences of some of our service members. Numerous people have contributed to this special issue: members of the Veterans Administration, civilian nurses, a retired career Navy nurse, newsletter committee members, and more. You will notice that the words “Veteran” and “Armed Forces” are capitalized throughout the issue. This signifies honor, and there is an ongoing initiative to make this standard practice.

It is our hope that after reading this issue, civilian nurses will have a better understanding of what our service member colleagues experience as military nurses. We also hope to provide a better understanding of what it means to be a Veteran and how that relates to health care, as well as the systems in place to support the U.S. military. Most of all, the team at MedSurg Matters! and AMSN wants to acknowledge, thank, and salute our brave members who are serving or have served in the Armed Forces. You are our heroes. We hope this issue makes us better nurses as we care for those who have defended our country and kept us safe. Freedom isn’t free.

Molly McClelland, PhD, MSN, RN, CNSR, ACNS-BC
MedSurg Matters! Editor
Nurses Providing Care to Military Veterans in Civilian Hospitals

Deadline for Submission: June 30, 2017

MSNN1503

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Objectives
The purpose of this continuing nursing education article is to increase nurses’ and other health care professionals’ awareness of appropriate care for military Veterans in civilian hospitals. After studying the information presented in this article, you will be able to:
1. Identify the five branches of the United States military service and their missions.
2. Discuss common health-related issues that affect Veterans.
3. Explain assessment and care strategies that should be used when treating Veterans in civilian hospitals.

Note: The authors, editor, editorial board, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity is jointly provided by Anthony J. Jannetti, Inc. and AMSN.

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According to a 2012 report published by the United States Census Bureau, there are more than 22 million Veterans living in this country, and over nine million of them are age 65 or older. Recent reports suggest that nearly 75% of Veterans receive medical and nursing care outside of the Veterans Affairs (VA) medical facilities, meaning they are most likely receiving care from civilian and non-military trained health care providers (Johnson, Boudia, Freundl, Anthony, Gmerek, & Carter, 2013). These statistics have significant implications for civilian medical-surgical nurses. Most nursing curricula do not include Veteran-specific care in their programs, so practicing civilian nurses in civilian hospitals have little to no training regarding how to care for the unique needs of Veterans. This article describes some common health-related issues for Veterans and tips on how civilian medical-surgical nurses might be able to provide better Veteran-specific care.

The Branches of Service

One of the most important and meaningful questions a medical-surgical nurse can ask a patient when completing an intake assessment is whether the patient has ever served in the Armed Forces. Johnson and colleagues (2013) published detailed assessment questions that would be useful when doing an intake history on a patient who has served in the military. Nurses should ask questions in a clear and non-judgmental manner. Assessment questions begin with asking patients if they have served in the military. If so, were they deployed? Did they experience any blasts, explosions, or accidents while deployed? Nurses should progress into more specific and often personal and sensitive questions, such as a history of sexual trauma, substance abuse, or anger problems during active duty or post-deployment (Johnson et al., 2013). Figure 1 illustrates a flow chart of some of these assessment questions.

It is important to ask and recognize the branch of service in which the patient served. The United States has five branches of military service: Marines, Army, Navy, Air Force, and Coast Guard. The Marine Corps is housed under the Department of the Navy. The Coast Guard is charged with protecting waterways within the United States borders. The Coast Guard is housed under the Department of Homeland Security as opposed to other branches of the military, which are housed under the Department of Defense (DoD). Patients may have served in a part-time capacity for the Army or Air Force, known as the Army National Guard and the Air Guard; the Navy and Marines don’t have a part-time option.

Patients may have served as enlisted members, meaning they are highly trained by a specific branch of the military and hold a minimum of a high school diploma. Many career-enlisted members have advanced degrees. For example, many officers serving longer than three years probably hold a Master’s Degree. Numerous enlisted members, holding the rank of E-7, typically have an Associate’s, Bachelor’s, or Master’s Degree in a given subject.

A patient’s time in the service may consist of a short term of two years or as long as an entire career. Military members are eligible to retire after 20 years of service. Some patients who have served as active duty for several
Figure 1. Strategies for Civilian Nurses Caring for Veteran Patients

- Ask patient if he or she has ever served in the Armed Forces during initial intake interview.
  - Yes: Ask what branch, when served, and rank. (Document answers.)
  - No: Proceed with initial assessment per hospital protocol.

- Ask patient if deployed and/or served during wartime.
  - Yes: Ask patient if he or she experienced any traumatic events while serving, such as combat, casualties, personal injuries, injuries/death of comrades, or exposure to hazardous materials/shrapnel.
  - No: Ask if patient is aware of any health-related issues (including sexual violence) associated with military service.
    - Yes: Request additional information and document findings. Obtain necessary consults (pastoral care, social work, give VA resource information, etc.).
    - No: Document findings.

- Ask patient if he or she could provide additional details.
  - Proceed with caution and be sensitive. Many combat Veterans are reluctant to share their experiences with civilians.
  - Do not assume patient has PTSD. Do not force Veteran to discuss further if unwilling to provide additional information. Ask patient if he or she would like assistance or support including: assistance in filing for compensation related to service, pastoral care, social work services, mental health services, assistance with post-deployment issues, substance abuse support group information, links to VA services/hotlines, or pain management.
  - Assess patient for evidence of substance abuse and depression/suicidal thoughts.
  - Assess patient’s housing situation (a high percentage of homeless people are Veterans).
  - Offer information specific to any positive findings from assessment. See Johnson et al. (2013, Table 1, p. 26-27) for resources.

- Other:
  - Consider developing a Veteran Champion or liaison for your hospital unit.
  - Request that your hospital’s Volunteer Services hire/use Veterans who would be willing to talk with patients. Veteran patients may be more likely to talk with another Veteran rather than a civilian.

Source: Adapted from Johnson et al., 2013.
years may have chosen the option to return to civilian life, but remain in the Military Reserves. This means they are on-call if the United States needs their service. Military Reserve members continue with military training periodically throughout the year.

Patients who served as officers in the military hold a minimum of a college degree and completed the Reserve Officers’ Training Corps (ROTC), attended Officer Candidate School (OCS), or graduated from one of the following military academic academies: the Naval Academy (Navy and Marines), West Point (Army), the Air Force Academy (Air Force), or Coast Guard Academy (Coast Guard). Officers are in charge of the enlisted members and operations, and both have served together in very difficult and tumultuous situations to protect the lives of American citizens.

Patients who are military Veterans served in diverse environmental conditions. Soldiers in the Army most likely served on the ground or in the air. Sailors in the Navy most likely served on the waterways, in the air, or ground forces. Marine Veterans could have been assigned duties on the waterways, ground, or in the air. Air Force Veterans (referred to as airmen) probably spent the majority of their time protecting the airways.

It is important for nurses to refer to service men and women by their correct titles. While there is a sense of unity among the entire DoD, there is a healthy competition between the branches. A sailor will not want to be referred to as a soldier, nor will a soldier want to be called an airman. The simple act of using the correct terminology can help ease a Veteran and allow for improved nurse-patient interaction in the civilian setting (see Table 1).

### Common Health Issues in Veterans

Military Veterans and active duty service members frequently have health issues that civilian patients may not experience; medical-surgical nurses need to be cognizant of these. Issues such as post-traumatic stress disorder (PTSD), polytrauma (multiple traumatic injuries), exposure to hazardous traumatic materials, burns, increased risk for substance abuse, risk of suicide, chronic pain, and alteration in self-image are a few of the health-related issues nurses need to assess for in their Veteran patients (Johnson et al., 2013).

Veterans should be assessed for the aforementioned conditions, but nurses should not assume that these conditions are present with every Veteran. In this issue of MedSurg Matters!, Pearson (2015) states that while PTSD does exist, not all Veterans experience the condition. It should not be assumed that all Veterans have the condition just because they were deployed and/or served in combat. The specifics of what a Veteran may have experienced during deployment are linked to the presence and severity of PTSD.

A familiar and recent example of a Veteran suffering from severe PTSD is the story of World War II hero Louis Zamperini, whose story was retold in the recently released movie, “Unbroken” (Pierce, 2015; Universal Studios, 2014). Mr. Zamperini was involved in a plane crash, drifted at sea for 47 days, and was then captured by the Japanese and tortured as a prisoner of war (POW) for several years until the war ended. When he finally returned to the United States, he suffered from nightmares and chronic pain related to his experiences as a captured soldier. He began abusing alcohol, getting into fights, and was almost divorced because of untreated PTSD (Hillenbrand, 2010).

Post-traumatic stress disorder can also result from activities service members are required to perform. A notable example of this was the Navy SEAL (Sea, Air, and Land special forces team) Chris Kyle, a highly skilled sniper who was ordered to kill many enemies of the United States in order to save and protect American lives. In addition to performing such difficult tasks, he was shot twice and was the victim of six separate improvised explosive device (IED) explosions (Schabner, 2013). Veterans who have been deployed and are returning to civilian life should be assessed for substance abuse, depression, sleep disturbances, and physical violence: all are common findings in patients with PTSD (Johnson et al., 2013).

Veterans may experience significant alterations in body image and require skilled nursing interventions related to polytrauma and loss of limbs. According to the Department of Veterans Affairs (2010), *polytrauma* is defined as “two or more injuries sustained in the same incident that affect multiple body parts or organ systems and result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities” (p. 2). Nurses need to be sensitive to Veterans and service members who have suffered polytrauma as a result of their service in the Armed Forces.

Another recent example of someone who sustained significant emotional turmoil following polytrauma during the Iraq War is Army Veteran Sergeant (Sgt.) Noah Galloway. Sgt. Galloway was serving a second tour of duty in Iraq with the 101st Airborne Division when he was hit by a roadside bomb. The explosion traumatically amputated his left arm, left leg, and caused severe injuries to his right leg and jaw. Sgt. Galloway was unconscious for five days. He was treated first in a hospital in Germany and then transferred to Walter Reed Army Medical Center in Washington, DC. Following a lengthy recovery and rehabilitation period, the once fit and competitive Army Sergeant started smoking and drinking, severed relationships with friends, became depressed, stopped physical training, and was spiraling into an overall unhealthy lifestyle (Mosbergen, 2015). Fortunately, Sgt. Galloway was able to recover from his emotional and physical decline and is now using his experience to help others. He is currently appearing on the TV show ‘Dancing with the Stars’ and often gets standing ovations for his determination and service to his country.

Sgt. Galloway’s story is very similar to many other wounded and traumatized Veterans. Nurses need to be aware that wounded Veterans are at high risk to begin unhealthy lifestyle
The Marine Corps has been America’s expeditionary force in readiness since 1775 and is the oldest service branch. Marines are forward deployed to respond swiftly and aggressively in times of crisis. Marines are soldiers of the sea, providing forces and detachments to naval ships and shore operations. Marines are global leaders, developing expeditionary doctrine and innovations that set the example and leading other countries’ forces and agencies in multinational military operations. These unique capabilities make the Marines “First to Fight” and our nation’s first line of defense.

The Army’s mission is to fight and win our Nation’s wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders. The Army does this by: Executing Title 10 and Title 32 United States Code directives, to include organizing, equipping, and training forces for the conduct of prompt and sustained combat operations on land and accomplishing missions assigned by the President, Secretary of Defense, and combatant commanders, and transforming for the future.

By law, the Coast Guard has 11 missions (listed in order of percentage of operating expenses):
- Ports, waterways, and coastal security
- Drug interdiction
- Aids to navigation
- Search and rescue
- Living marine resources
- Marine safety
- Defense readiness
- Migrant interdiction
- Marine environmental protection
- Ice operations
- Other law enforcement

Thus, the Coast Guard is military, multi-mission, and maritime.

The mission of the Navy is to maintain, train, and equip combat-ready naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas.

The mission of the United States Air Force is to fly, fight, and win… in air, space, and cyberspace.

To achieve that mission, the Air Force has a vision of Global Vigilance, Reach, and Power. That vision orbits around three core competencies: developing airmen, technology to war fighting, and integrating operations. The Air Force bases these core competencies and distinctive capabilities on a shared commitment to three values: 1) Integrity first, 2) Service before self, and 3) Excellence in all we do. This is the motto of the Air Force.

<table>
<thead>
<tr>
<th>Branch</th>
<th>Est.</th>
<th>Title</th>
<th>Mission</th>
<th>Titles/Ranks (Highest to Lowest)</th>
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<tbody>
<tr>
<td>Marines</td>
<td>1775</td>
<td>Marine</td>
<td>The Marine Corps has been America’s expeditionary force in readiness since 1775 and is the oldest service branch. Marines are forward deployed to respond swiftly and aggressively in times of crisis. Marines are soldiers of the sea, providing forces and detachments to naval ships and shore operations. Marines are global leaders, developing expeditionary doctrine and innovations that set the example and leading other countries’ forces and agencies in multinational military operations. These unique capabilities make the Marines “First to Fight” and our nation’s first line of defense.</td>
<td>ENLISTED&lt;br&gt;Sergeant Major of the Marine Corps, Sergeant Major, Master Gunnery Sergeant, First/Master Sergeant, Gunnery Sergeant, Staff Sergeant, Sergeant, Corporal, Lance Corporal, Private First Class, Private&lt;br&gt;OFFICERS&lt;br&gt;Same as Army (see below).</td>
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<tr>
<td>Army</td>
<td>1789</td>
<td>Soldier</td>
<td>The Army’s mission is to fight and win our Nation’s wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders. The Army does this by: Executing Title 10 and Title 32 United States Code directives, to include organizing, equipping, and training forces for the conduct of prompt and sustained combat operations on land and accomplishing missions assigned by the President, Secretary of Defense, and combatant commanders, and transforming for the future.</td>
<td>ENLISTED&lt;br&gt;Sergeant Major of the Army, Command Sergeant Major, Sergeant Major, First Sergeant, Master Sergeant, Sergeant First Class, Staff Sergeant, Sergeant, Corporal, Specialist, Private First Class, Private 2, Private&lt;br&gt;OFFICERS&lt;br&gt;General, Lieutenant General, Major General, Brigadier General, Colonel, Lieutenant Colonel, Major, Captain, First Lieutenant, Second Lieutenant, Chief Warrant Officer (5–2)</td>
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<tr>
<td>Coast Guard</td>
<td>1790</td>
<td>Seaman or Sailor</td>
<td>By law, the Coast Guard has 11 missions (listed in order of percentage of operating expenses):&lt;br&gt;- Ports, waterways, and coastal security&lt;br&gt;- Drug interdiction&lt;br&gt;- Aids to navigation&lt;br&gt;- Search and rescue&lt;br&gt;- Living marine resources&lt;br&gt;- Marine safety&lt;br&gt;- Defense readiness&lt;br&gt;- Migrant interdiction&lt;br&gt;- Marine environmental protection&lt;br&gt;- Ice operations&lt;br&gt;- Other law enforcement&lt;br&gt;Thus, the Coast Guard is military, multi-mission, and maritime.</td>
<td>ENLISTED&lt;br&gt;Master Chief Petty Officer of the Coast Guard, Command Master Chief Petty Officer, Master Chief Petty Officer, Senior Chief Petty Officer, Chief Petty Officer, Petty Officer (3rd–1st Class), Seaman/Airman, Seaman/Airman Apprentice, Seaman Recruit&lt;br&gt;OFFICERS&lt;br&gt;Same as Navy (see below).</td>
</tr>
<tr>
<td>Navy</td>
<td>1798</td>
<td>Sailor</td>
<td>The mission of the Navy is to maintain, train, and equip combat-ready naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas.</td>
<td>ENLISTED&lt;br&gt;Master Chief Petty Officer of the Navy, Fleet/Command Master Chief Petty Officer, Senior Chief Petty Officer, Chief Petty Officer, Petty Officer (3rd–1st Class), Seaman, Seaman Apprentice, Seaman Recruit&lt;br&gt;OFFICERS&lt;br&gt;Fleet Admiral (wartime only), Admiral Chief of Naval Operations/Commandant of the Coast Guard, Vice Admiral, Rear Admiral (Upper &amp; Lower), Captain, Commander, Lieutenant Commander, Lieutenant, Lieutenant Junior Grade, Ensign, Chief Warrant Officers (5–2)</td>
</tr>
<tr>
<td>Air Force</td>
<td>1907</td>
<td>Airman</td>
<td>The mission of the United States Air Force is to fly, fight, and win… in air, space, and cyberspace.&lt;br&gt;To achieve that mission, the Air Force has a vision of Global Vigilance, Reach, and Power. That vision orbits around three core competencies: developing airmen, technology to war fighting, and integrating operations. The Air Force bases these core competencies and distinctive capabilities on a shared commitment to three values: 1) Integrity first, 2) Service before self, and 3) Excellence in all we do. This is the motto of the Air Force.</td>
<td>ENLISTED&lt;br&gt;Chief Master Sergeant of the Air Force, Command Chief Master Sergeant, Chief Master Sergeant (Diamond), Chief Master Sergeant, Senior Master Sergeant (Diamond), Senior Master Sergeant, Master Sergeant (Diamond), Master Sergeant, Technical Sergeant, Staff Sergeant, Senior Airman, Airman First Class, Airman, Airman Basic&lt;br&gt;OFFICERS&lt;br&gt;General of the Air Force, General Air Force Chief of Staff, Lieutenant General, Major General, Brigadier General, Colonel, Lieutenant Colonel, Major, Captain, First Lieutenant, Second Lieutenant</td>
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**Sources:** Adapted from Military Factory, 2015; United States Air Force, 2014; United States Army, 2015; United States Marine Corps, 2015; United States Navy, 2015.
practices (especially following polytrauma and amputations). Nurses need to provide teaching, support, and frequent assessments to both the Veteran and his or her family members in order to quickly recognize alterations in the ability to adequately cope with military experiences.

Many active service members and Veterans return from deployment or retire from the military without traumatic injuries, yet still have unique health needs requiring nursing care. For example, back, neck, and other joint pain is a common finding in Veterans, which can be related to carrying heavy loads (often over 100 pounds) in their packs. Female Veterans also have specific health care needs related to their time in the service, such as physical limitations, sexual issues, gynecological and maternity issues, and psychological impact of leaving children at home. There are some common nursing assessment questions (as shown in Figure 1) that should be implemented when providing care to an identified Veteran in a civilian health care facility.

These initial assessment and intervention strategies are crucial.

Conclusion

Caring for military Veterans requires additional nursing assessment and intervention strategies and care beyond that of civilian patients. The unique experiences of service members can only be known to other service members. Civilians cannot fully comprehend the experience of serving in the Armed Forces, nor should they pretend to. Nurses should become familiar with the different branches of service, ranks, and missions of the branches; properly acknowledge and thank their Veteran patients for their service to the country; assess for Veteran-related health issues; and quickly intervene to prevent unhealthy behaviors and practices in Veteran patients. Civilian nurses owe a debt of gratitude to the men and women who have fearlessly defended America and can give back to them by providing excellent Veteran-centered care.

References


Becoming a Nurse and Army Officer Through the ROTC Program

I am a young woman who has grown to seek knowledge and honor through the respect that I show for myself and others. I take personal responsibility for all of my actions. My family and friends have placed high standards on me, and this makes me strive for excellence in my life. However, I was not always as disciplined as I am now. Here is my story.

As a high school sophomore, I didn’t know much about college. I really wasn’t sure that college was for me, but I submitted college applications just as my peers did. I applied because it felt like the right thing to do; that’s what everyone else my age was doing. However, on college career days, I always found myself speaking with recruiters from different branches of the military. At the end of my third year in high school, I decided that I was going to join the military immediately after I graduated. I reached out to a recruiter and began sharing the news with my family and friends about my decision to enlist. Around that same time, I began receiving acceptance letters from the colleges and universities throughout Michigan that I had applied to. In my senior year, I received an acceptance letter from the University of Michigan-Ann Arbor (U-M). At that point, I made the decision to attend college and place my desire for the military on hold. During my first year at U-M, I saw many service members on campus and realized I could get involved too. It hadn’t occurred to me to combine my two desires – college and military service.

While studying abroad in Costa Rica, I met an Army Reserve Officers’ Training Corps (AROTC) cadet. She talked to me about ROTC and gave me contact information for an AROT C faculty member. I talked to the faculty to get more information and to discuss entry requirements. I was ecstatic when I discovered there was a way for me to attend college courses and train to become a Second Lieutenant in the United States Army upon graduating.

As an ROTC recruit, I had to attend a weekly ROTC course. I, and the other ROTC recruits, also conducted hands-on training during lab hours each week. Physical training early in the morning several times a week was an additional requirement. Once a semester, there were practical exercises with other ROTC programs where we applied our knowledge. ROTC offers a variety of other benefits such as scholarship for tuition, room and board, and books, as well as a monthly stipend. In return, you must commit to serve in the military as an officer for the designated time in your contract.

Although my plan was to commission as a Second Lieutenant and enter the Nursing Corps, I actually graduated from U-M with a psychology degree and went into the Medical Service Corps. Currently, I am a First Lieutenant in the Army National Guard and a first semester senior in the McAuley School of Nursing at University of Detroit Mercy. I am planning to graduate in December 2015. The AROT C was one of the most important experiences that served as the foundation in building who I am today.

For those considering an undergraduate or graduate degree in nursing, enrolling in an ROTC program offers many benefits. Depending on the branch of ROTC and the school you attend, you must meet the height and weight requirement, pass the physical fitness test, and take an entry knowledge exam and other similar requirements. In addition to attending your scheduled nursing classes, you will have a course each semester for ROTC, attend physical fitness training, perform training exercises, participate in ROTC events, and more.

Upon graduating from your nursing program, you will receive your Bachelor of Science in Nursing and commission as an officer into your respective branch. Being a registered nurse in the civilian world cannot compare to what the military can offer you as far as enhancing your leadership and critical-thinking abilities. If you are interested, speak with a recruiter for the branch that interests you to learn more about the endless opportunities.

Erica Blue, BSNc, is First Lieutenant, United States Army National Guard, Medical Service Corps.

Disclaimer: The views expressed in this article are those of the author and do not reflect the official policy or position of the Army National Guard, Department of Defense, nor the U.S. Government.

Author’s Note: I am a military service member. This work was prepared as part of my official duties. Title 17 U.S.C. 105 provides that “Copyright protection under this title is not available for any work of the United States Government.” Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person’s official duties.

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Moral Injury is the Wound: PTSD is the Manifestation

Since 2012, the Academy of Medical-Surgical Nurses (AMSN) has actively educated our nurses about war-related injuries and the special care that nurses can provide to returning Veterans. AMSN actively became involved in the Joining Forces Initiative, a national program spearheaded by Michelle Obama and Dr. Jill Biden, to ensure that returning Veterans are supported through employment, health care access, and educational opportunities (The White House, 2012). As a follow-up to the association’s involvement in Joining Forces, this article focuses on how moral injury is the kindling (Guntzel, 2013), and post-traumatic stress disorder (PTSD) is the fire that families, health practitioners, and others often see. Williamson and Mulhall (2009) estimated that at least 20% of Veterans returning from Iraq and Afghanistan demonstrate signs and symptoms of PTSD. Just 20% of World War II soldiers discharged their weapons, whereas 95% of soldiers in today’s wars discharge their weapons (Knowles, 2013). Drescher and colleagues (2011) suggested that soldiers often grapple more with killing others than with worrying about harm that might befall them. Bedside nurses witness and care for everyday trauma victims, but there are important considerations in care delivery when the trauma has the antecedent of moral injury.

Guntzel (2013) defines moral injury as having three important components: (1) betrayal of what the soldier knows is right, (2) by someone who holds authority, and (3) occurs in a high-stakes situation. Moral injury causes the soldier to experience personal devastation that is grounded in shame and guilt because the soldier either killed someone, was ordered to kill someone, or could have stopping a killing and didn’t (Guntzel, 2013). The effects of moral injury are ravaging, in that the soldier loses sight of his or her ideals, attachments, and ambitions (Guntzel, 2013).

In World War I, PTSD was called Shell Shock (Jones, 2012). In more recent times, we refer to the lasting and cumulative effects on the autonomic nervous system as PTSD (Schore, 1994). PTSD is classed as an anxiety disorder associated with a threat to one’s life and overwhelming fear (Drescher, Nieuwmsma, & Swales, 2013). PTSD is characterized by hyperarousal, hypervigilance, intrusive imagery, flashbacks, nightmares, panic attacks, anxiety, phobias, depression, mood swings, and personal disenfranchisement (Schore, 1994). Nightmares are encoded or hard-wired into the brain’s circuitry and remain within the soldier’s brain (Knowles, 2013), and can be recalled and relived by any of the senses (e.g., a triggering smell, sight, or sound). Nightmares represent a crisis of psychic damage; therefore, medications that don’t actually impact the hard-wiring of the brain often have limited value (Knowles, 2013). Nurses are educated in pharmacological interventions, but must also be aware of limitations and consider the largesse of the psychic damage to include other interventions, such as spiritual guidance, cognitive-processing therapy (Steenkamp et al., 2011), and grief counseling.

Drescher and colleagues (2011) suggested that there is an array of other symptoms that may not fit into the PTSD diagnosis per se, but are described in returning Veterans who present with PTSD: changes in ethical attitudes and spirituality, guilt, forgiveness problems, distrust in others, aggressive behaviors, and poor self-care. As the wars in Afghanistan and Iraq bring Veterans home, it is essential that bedside nurses understand the antecedents to PTSD so that they can not only provide effective and sensitive care, but also be knowledgeable about current studies and available resources to help our Veterans live more peacefully. Nurses can shift their thinking from PTSD symptom management to broader considerations that create an environment to support moral repair (Drescher et al., 2011).

Shay (2002) suggested that, while traditional medical-behavioral therapies are helpful with guilt, a multi-pronged approach must be considered to alleviate moral pain, such as spiritual interventions. Bedside nurses can consider a wide array of helpers beyond the typical patient consults. It is essential that the nurse offer active listening and presence when caring for the returning Veteran, as Veterans can feel that others don’t understand their experiences and would be shocked to hear about what actually happened (Stallinga, 2013). Often soldiers feel alone upon returning from war (Drescher et al., 2011). A basic principle of nursing is to help the patient (Veteran) to attain his or her highest level of functioning, which, beyond ambulation, feeding, and infection control, must also challenge the nurse to consider ways to help the patient (Veteran) to reconnect with civilian life (Stallinga, 2013). Litz and colleagues (2009) described a specific treatment strategy called Dialogue with a Benevolent Moral Authority, which leads to self-forgiveness and ultimately reconnection. This modality creates a scene where the patient (Veteran) speaks from the soul with a benevolent moral authority that often includes an empty chair dialogue using imaginary conversation with a person to whom the patient (Veteran) has great respect (Litz et al., 2009). Alternatively, the patient (Veteran) can speak with a trusted service member, Veteran, or buddy, for whom their insights and understanding are of importance and trusted (Litz et al., 2009). Gray and colleagues (2012) similarly described the use of Adaptive Disclosure, which is a modified form of cognitive behavior therapy that allows patients (Veterans) to name that which is
burdening their soul: shame, self-loathing, and guilt. Preliminary study results of 44 active-duty Marines and Navy personnel at Camp Pendleton in California suggest that Adaptive Disclosure, which affects hard-wired connections, has been helpful with PTSD and associated grief and loss (Gray et al., 2012).

Though bedside nurses are not specifically trained in these modalities, just knowing about such interventions can empower the nurse to suggest or advocate for such services and options. Nurses are encouraged to recall and maintain a truly holistic approach to our returning Veterans and their unseen injuries.

References


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Nursing and Health Care in the Veterans Health Administration Today

Perry C. Goldstein

This MedSurg Matters! article was conceptualized as a review of changes and improvements in the U.S. Department of Veterans Affairs (VA) – with a focus on nursing services – in response to a series of scandals that were uncovered in the VA health care system last year (Coburn, 2014). In addition, this author had personal experience attempting to obtain VA hospital services for one Veteran in the state of Georgia with dismal results. In August 2013, this author attempted to enroll a Vietnam Veteran in the Veterans Health Administration (VHA) for desperately needed cancer treatment. We completed all applications, obtained all necessary Department of Defense (DoD) forms (including honorable discharge certificate), and were repeatedly discouraged or ignored by case managers from the VA as well as those in public and private sectors. In addition, due to a lack of available beds in the patient’s home VA region, he was referred to a VA hospital in Tennessee – over 130 miles away – for treatment. After a period of four months, the family stopped attempts to transfer the patient to a VA facility (where beds were still unavailable) and, out of sheer frustration, the patient accepted hospice care at home.

This author has attempted to contact (via telephone) Veterans’ Affairs representatives from the state of North Carolina and the state of Tennessee, as a member of the Editorial Committee of this publication, for new information related to this article. However, voicemail boxes have been full and unable to accept new messages or when a message was left, no return phone calls were received. The questions submitted are listed in Figure 1. In addition, a nurse and senior VA health care executive employed in the Office of Clinical Strategic Planning and Measurement at the U.S. Department of Veterans Affairs informed this author “written administrative approval” is now required for any interviews or discussion of activities in the VA health care system. At this time, this author has attempted to submit a series of questions to this same senior nurse executive.

For readers also interested in contacting/communicating with the Veterans’ Affairs Committee, the current members’ names are available online (House Committee on Veterans’ Affairs, 2015).

For those unfamiliar with the serious deficiencies discovered within the VA health care system, a review of the findings is now presented. The report on the VA health care system, authored by Senator Tom Coburn (R-OK), concluded that more than 1,000 Veterans died over the last decade as a result of a failure to provide care or malpractice by the Department of Veterans’ Affairs (Coburn, 2014).

The report summarizes the findings of a number of government and media investigative reports. The report also sug-
gests that the VA routinely performed unnecessary preventive care, did not process claims in a timely fashion, has employed medical staff to service the growing Veteran population in the U.S. (113th U.S. Congress, 2014b). How has this affected hiring of additional medical staff to service the VA system? Does the VA reimburse nurses for clinical certifications and advanced degrees? Has the VA considered a system-wide pay scale, rather than relying on local-market median salaries as the basis for various VA medical personnel to increase quality of care provided at each facility?  

5. Nursing retention: Is there data currently available on a regional level for retention of nurses within the following specialties in the VA system?  
   a. ER Nurses  
   b. Med-Surg Nurses  
   c. ICU/Critical Care Nurses  
   d. Surgical/PACU Nurses (Hospital-Based)  
   e. Outpatient Clinic Nurses/Outpatient Day Surgery  

6. Quality, staff, and patient satisfaction: As part of improvements in the VA health care system, in congressional testimony, Secretary McDonald indicated that the VA is, “building a more robust continuous system for measuring patient satisfaction to provide real-time, site-specific information…” Is the VA health care system currently using or considering use of any of the following commercially available quality and satisfaction measures that most non-VA hospitals subscribe to in order to meet current JCAHO, Medicare, and Medicaid quality of care and patient satisfaction requirements?  
   c. Core Measure Sets from The Joint Commission http://www.jointcommission.org/core_measure_sets.aspx  

If the VA health care system is not using these systems, could you describe the specifics that the VA system is using and where data regarding similar indicators can be found?

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**Figure 1.** Questions for the Veterans Health Administration, Presented to the Office of Clinical Strategic Planning and Measurement at the U.S. Department of Veterans Affairs

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1. Initial registration for VA health care benefits:  
   How long should it now take for any honorably discharged Veteran to become enrolled in the VA health care system and receive a Veterans Health ID Card (VHIC) or number after the initial date of application, regardless of degree of benefits they are entitled to?  

2. Transfer enrollment to VA health care from private or Medicare/Medicaid coverage:  
   What is the process for any Veteran to shift his or her primary insurer to the VA system (if eligible) if he or she already has Medicare/Medicaid as a primary provider? Are there certain situations where Veterans would not be eligible to shift their primary care provider to the VA?  

3. Determination of medical benefits for Veterans:  
   How is the extent of VA health care benefits determined? Clearly, there are differences in eligibility determined by type of service (combat troops versus non-combat troops, etc.) and length of service. Are there standard formulas for computing the benefits available? If so, where can they be found? Can Veterans pay the VA system to supplement annual benefits much like Medicare-Medigap policies if they are not eligible for “full” benefits? If they are not eligible for full benefits, are there discounted commercial “add-on” policies available for purchase?  

4. Nursing employment and salaries:  
   After passage of the recent H.R.3230, “Veterans Access, Choice, and Accountability Act of 2014,” Congress authorized $5 billion for the hiring of additional medical staff to service the growing Veteran population in the U.S. (113th U.S. Congress, 2014b). How has this affected hiring of nurses and nursing salaries in the VA system? Is there a clinical ladder for nurses in the VA system? Does the VA reimburse nurses for clinical certifications and advanced degrees? Has the VA considered a system-wide pay scale, rather than relying on local-market median salaries as the basis for various VA medical personnel to increase quality of care provided at each facility?

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      http://www.hcahpsonline.org/home.aspx  
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The VA health care system is undergoing major changes designed to improve speed of registration and scheduling for service with better responsiveness for care requests. At this time, information available regarding actual changes is only available from published websites, as personal contacts with VA staff have been difficult to establish. Reports from at least one large university teaching hospital suggest there have been some positive changes in care offered to Veterans in Tennessee (P. Bell, personal communication, March 12, 2015). More data and further evaluation will need to be collected. Readers will be updated with new information as it becomes available through the inquiry presented to the VHA in Washington, DC.

References


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My Career as a Navy Nurse

Mary Beth Owens

When people find out I spent 22 years in the Navy, I often get asked why I joined, and why the Navy? Those are easy questions to answer. As cliché as it sounds, I wanted to serve my country. I come from a Navy family, so I really didn’t think about any other branch of the service. Besides, everyone knows the Navy has the best duty stations.

I joined the Navy in 1979, after graduating from nursing school. All staff officers go to Officer Indoctrination School in Newport, Rhode Island (now called Officer Development School). It is a five-week course where you learn about Navy customs and traditions, military etiquette, and leadership. Its main focus is to teach staff officers (nurses, doctors, pharmacists, physical therapists, etc.) how to function in their new role as a Naval Officer. It is that role that is the biggest difference between being a nurse in the Navy versus being a civilian nurse. The dual role of nurse and Naval Officer means that you have leadership responsibilities right from the start of your service. As you become more senior in rank, you will move into positions where you have more leadership responsibilities, such as Charge Nurse – Division Officer in Navy Speak – or a department head. Navy nurses also have a large responsibility in teaching corpsmen, who provide much of the bedside care.

Clinically speaking, how is Navy nursing different from civilian nursing? Honestly, it’s not much different, unless you are assigned to a ship or deployed to a combat zone. Just about any specialty you can do as a civilian you can do in the Navy. While many of your patients will be active duty personnel, you will also care for their families and for retired folks. Serving in the Navy, you can have as diverse a career as you might want. I think my career is very typical of what a career as a Navy Nurse can be like.

My first tour of duty was to the Naval Hospital in Oakland, California, where I was assigned to the orthopedic ward. When I first joined the Navy, we were working eight-hour shifts, so you had a rotating schedule of working a week or two of the a.m. shift, a week of p.m. shift, and a week of night shift. The only good thing about working the night shift was that after working seven nights in a row, you got a four-day weekend. Many a mini-vacation was planned for those four days off! During my time at “Oaknoll,” I was promoted in rank twice and given the position of PM shift charge nurse, and later, assistant charge nurse of the ward.

My next duty station was the Naval Hospital, at Bethesda, Maryland. I was again assigned to an orthopedic ward in the position of Assistant Charge Nurse. About mid-way through my three-year tour at Bethesda, I asked for, and was granted a request to move to the emergency room. I loved working in the ER. I enjoyed the fast pace and learning new skills. As part of my assignment to the ER, I was able to attend training in Advanced Trauma Life Support – essentially advanced training to deal with multiple casualties. Little did I know, I would put those skills to use in the not too distant future.

Being in the nation’s capital affords you some exposure to unique experiences. For instance, I was assigned to augment the White House medical staff during a State of the Union Address by President Reagan, and I traveled in a presidential motorcade to Camp David as supplemental medical staff.

After Bethesda, I was transferred to the Naval Hospital at Bremerton, Washington. This was a duty station I had been trying to get for a while. First, it was closer to my family, and secondly, as an avid outdoors person, I was really looking forward to doing some great hiking and backpacking. At this point in my Navy career, I was actively seeking a more formal leadership position. I was offered, and accepted, a position as Charge Nurse of a surgical/pediatric ward. What a combination that was to deal with. It definitely required a unique set of skills for my staff and to care for both adults and children simultaneously. As my first real leadership position, Bremerton holds a very special place in my heart. I really came into my own on a professional level and it was at Bremerton where I knew I would make the Navy my career.

I arrived at Bremerton in February 1989. In November 1990, the build up to the first Gulf War began (Operation Desert Shield/Storm), and I was deployed on the Hospital Ship USNS Mercy. Being deployed to a combat zone is both scary and exciting. Scary, well because it’s a combat zone, and exciting because you know you will be putting to use skills and training you have gone through, but hoped you wouldn’t ever have to use.

Along with about 200 other medical personnel, I was flown to Subic Bay in the Philippines. There, we awaited the arrival of the Hospital Ship USNS Mercy. It had left the San Francisco Bay area with a skeleton crew about two weeks before our arrival in the Philippines. The Mercy, and its sister ship, the Comfort, are converted oil tankers, and the only two hospital ships in the Navy. We left the Philippines and sailed to the Persian Gulf, where we weighed anchor off the coast of Bahrain. This was where we stayed for the bulk of the war.

I was assigned to Casualty Receiving – essentially the emergency room of the ship. We formed several treatment teams, one of which I was privileged to lead. The teams consisted of two Nurse Corps officers, and several corpsmen. In the build-up to actual combat, we trained, and trained, and trained. We ran many multiple casualty drills and honed our
Guam is a small island in the Pacific, about 30 miles long and 10 miles wide at its widest point. Guam and the surrounding area are steeped in WWII history. As a history buff, that alone made this assignment an interesting one for me. Having long had a desire to become a nurse practitioner, I was finally able to achieve a goal of working in ambulatory care and was assigned as the Division Officer of the Family Practice Clinic. Our clinic saw about 2,500 patients a month, and I was responsible for 12 corpsmen and three civilians (including one nurse and two administrative personnel). I was heavily involved in patient education, running a cholesterol and hypertension clinic, a pre-natal education class, and a diabetic education class. I was also given the opportunity to deploy on a submarine tender for a few weeks as a temporary assignment. A submarine tender is a surface ship that “tends” submarines, providing them with support – mostly repairing equipment and servicing the nuclear power plants on subs. Our tender was the USS Holland, which had a crew compliment of approximately 1,300 (270 of whom were women). An OB/GYN physician and I went aboard to provide some women’s health care and education. Additionally, we helped with routine sickbay operations and participated in many shipboard drills. Another fun thing we did was to cross the equator. There is a long-standing tradition of “crossing the line” that occurs aboard any naval vessel that crosses the equator. Those of us who were “pollywogs” were required to complete this rite of passage in order to become a “shellback.” It is a daylong initiation involving many rituals that I cannot divulge. I will say that it was quite the experience – one I am glad to have been able to participate in, but also one I would not want to repeat.

Guam was another great duty station for outdoor activities and for travel. Our recreation department organized weekly “boonie stomps,” which were hikes into the surrounding countryside. Many of the places we hiked to were WWII historical sites. Scuba diving was also a very popular activity; the waters around Guam are clear to 90 feet or so and bathtub warm. Travel was another favorite pastime. I ventured to the surrounding islands of Saipan, Tinian, and Truk (more WWII historical sites) and to Bali and Japan.

From Guam, I was fortunate to be selected for a program called Full-Time Duty Under Instruction. Essentially, school becomes your duty station. The Navy pays your tuition, and you continue to earn your regular salary while attending school. After completing graduate school at the University of Washington, my first assignment as a women’s health nurse practitioner was to Naval Hospital Great Lakes. This is the only “boot camp” for the enlisted personnel in the Navy. I was assigned as the Division Officer of the Recruit Women’s Health Clinic. I worked with three other NPs, one OB/GYN physician, and about seven corpsmen. All of the recruits were required to undergo screening medical exams, which included gynecologic exams for all the female recruits. On our “inprocessing” days, each of the NPs would see somewhere between 40-50 recruits. The only way to do that was to have a very finely tuned process. The recruits were also given the option of starting (or continuing) contraception. After their exams, our corpsmen provided a health education session for the recruits that included safe sex practices, diet and exercise, and self-care measures for dealing with women’s health issues while deployed. Our non-inprocessing days were spent providing routine women’s health care. Our clinic saw approximately 15,000 female recruits and staff members per year. I was also selected to serve on a Women’s Health Strategic Planning Group. As assignments for women in the Navy expanded, a need was identified to ensure that active duty women were provided access to appropriate women’s health care wherever they might be assigned. It was our job to identify how to best meet those needs.

After Great Lakes, I was assigned to the Marine Corps Base at Camp Pendleton, where I worked as the Women’s Health Care Coordinator for all the branch clinics. I finished
A Sailor and a Nurse

I come from a family with a long history of serving its country. My dad was a marine, my brother a sailor, one grandfather a soldier, the other a sailor, and I could keep going. But that was not for me. In fact, in my senior year of high school, I told my dad, “I will NEVER join the military!” As you can guess, I have had to eat those words!

From a very young age, I knew what I wanted to do with my life. I can remember spouting my life plan to anyone who would listen. I wrote college and scholarship application essays on the subject. I was going to be a pediatrician specializing in genetic disorders. I am not even sure that was a specialty in the 1990s, but I was going to make it one. However, after two years of college, I found myself bored and dissatisfied. Why was I still sitting in Kentucky, bored, with the prospect of at least another six years in school, and who knows how much training afterwards? How was I even going to pay for it all? Some of my scholarships were running out, and my parents didn’t have that kind of money. It looked like I was going to have to incur tons of debt. Was that how I wanted to start my adult life? Thereafter, at the age of 20, I made a radical decision that would change the trajectory of my life. I joined the United States Navy.

I entered Recruit Training Command, Great Lakes, IL, in September 1996. I did not enter the Navy as a nurse nor as an officer. I was enlisted and destined for Naval Nuclear Power Training Command in Orlando, FL, to train as a Nuclear Electronics Technician, with the ultimate goal to serve as a Reactor Operator aboard an aircraft carrier. Over six years, I completed nuclear power training, reported to the USS George Washington (CVN-73), and qualified as a reactor operator. During that time, I met the love of my life and married. I continued to take college courses at the local community college and onboard ships. I completed two Mediterranean/Arabian Sea deployments. I was in the same battlegroup with the USS Cole when it was bombed on October 12, 2000. On September 11, 2001, we were on a normal workup cycle in the Atlantic Ocean, and I was standing watch as the Reactor Operator when those two airplanes hit the World Trade Center. Ultimately we sailed into New York Harbor to provide support and security.

These were some of the hardest things I have done in my life, but they prepared me for almost everything that would come later. The rigor, structure, and time constraints taught me efficiency, how to determine importance, and how to anticipate. The oral boards, interviews, and expectations to teach helped me overcome a fear of public speaking and made me realize I actually love teaching. The attention to detail engrained in every aspect of training and everyday life

out my career by returning to Recruit Training Command at Great Lakes and retired from the Navy in early 2003.

Would I do it all again? In a heartbeat. The Navy afforded me opportunities both professionally and personally that I never would have had otherwise. And though I am retired now, the service never really leaves you. I have a lifetime of memories and lifelong friends. It was an honor to put the uniform on every day. There is no better career than that.

Mary Beth Owens, APRN, is a Retired Commander, NC, United States Navy.

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taught me to notice details and nuances in everything (sometimes to a fault).

As a woman, I was part of the minority, and in the 1990s, a new minority to the nuclear field. This experience taught me how to better relate to others. But it also made me realize how resistant to change and malicious some people can be. I had to learn to be adaptable, take criticism, develop a thick skin, and most importantly, to be assertive and to defend others and myself. These experiences led me to realize that I wanted to be in a position to help others, to relate to people, and to make a difference in others’ lives. These experiences shaped who I am today and the nurse I became.

In 2001, I was selected for the Seaman-to-Admiral 21st Century Commissioning Program Nurse Corps Option. I attended the University of South Carolina (USC), Columbia, as a full-time nursing student and Officer Candidate in the USC Naval Reserve Officers’ Training Corps (ROTC) program. I was commissioned as an Ensign in the United States Navy in December 2005 and headed off to my first command, the National Naval Medical Center (NNMC), Bethesda, MD, as a new graduate RN.

I was excited and terrified, but I felt ready to conquer a new challenge. NNMC and Walter Reed Army Medical Center were receiving the majority of wounded warriors from Operation Iraqi Freedom and Operation Enduring Freedom. The 44-bed, multi-service surgical unit (5-East) that I ultimately worked on was consistently full with a majority of wounded warriors. The hallmark wounds from these wars are traumatic amputations, traumatic brain injury, and post-traumatic stress disorder (PTSD). I can remember my first day on the unit clearly. Young men – 18, 19, and 20 years old – missing limbs, many with multiple amputations, most with mild to severe brain injuries, and PTSD… And the equipment: wound-vacs, PCAs, epidurals… I was not nearly as prepared as I thought. I went home that first day and cried. What had I gotten myself into? What was I thinking? How would I ever be able to cope with this? What if I get deployed? Will this happen to me? I faced a barrage of emotions and questions that I could not begin to process or answer.

What I didn’t know yet, but learned very quickly, was that I was not alone. We were a team. A team that supported each other; that was there for each other; that never let anyone flounder or flail. We cried on each other’s shoulders and celebrated our triumphs. We helped our patients and families navigate through some of the most terrible, horrifying times of their lives. We laughed and cried with our sailors, marines, airmen, and soldiers. We assisted families in overcoming the obstacles of injury, allowing them to go home together or to find peace in their decisions. I learned more about people and nursing in those two years than any time before or since.

In my time at NNMC, I have worked in several different settings with different patient populations: outpatient surgery, general surgery, primary care, and staff education. The military is great at allowing its personnel to obtain varied experiences. You are always moving either within a command or between commands. You can expect a new experience every 1.5 to 3 years. It also allows opportunity for leadership very early. I trained as charge nurse after six months. After four years, I took over the clinic manager position of a general surgery clinic. Shortly thereafter, I assumed the role of division officer and senior nurse of a primary care clinic. Opportunities for leadership and staff development always exist. Military medicine is constantly evolving and in search of methods to improve training and practice, insisting that every environment is a training environment. You should always be teaching someone else to do your job, and you should always be learning your supervisor’s job. Continuing education is stressed. Many programs exist for enlisted personnel and officers to continue their education while working full-time with pay and benefits.

My time in the Navy has taught me a few very important things about myself and people in general. I can do anything that I set my mind to and work hard for. Never say never; something or somebody will make you eat those words. All people deserve the benefit of the doubt. Most people will flourish when given the appropriate tools, leadership, and encouragement.

In 18 years of military service, I have had the opportunity to live in many places in the United States: Illinois, Florida, New York, Virginia, South Carolina, and Maryland. I have visited many countries and territories: Canada, Mexico, Puerto Rico, St. Thomas, Cuba, Spain, Portugal, Italy, Greece, Turkey, Croatia, Bahrain, and United Arab Emirates. I have sailed in the Caribbean Sea and across the Atlantic Ocean, through the straights of Gibraltar, around the Rock of Gibraltar, across the Mediterranean Sea, through the Suez Canal, across the Red Sea, through the Straights of Hormuz, across the Arabian Sea, and back. I have flown in a helicopter over the Arabian Sea, landed on an aircraft carrier in the Caribbean Sea, and launched from an aircraft carrier in the Arabian. I have had the opportunity to continue my education within Navy schools, full-time duty under instruction, and while working. I am looking forward to my next adventure as an Adult-Gerontology Clinical Nurse Specialist and am grateful for my service to my country and my patients.

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Disclaimer: This article was written while the author was a student at the University of Virginia studying for a Masters of Science in Nursing Adult-Gerontology Clinical Nurse Specialist. The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

Author’s Note: I am a military service member. This work was prepared as part of my official duties. Title 17 U.S.C. 105 provides that “Copyright protection under this title is not available for any work of the United States Government.” Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person’s official duties.
Discharging Veterans: Legal and Ethical Issues

As nurses, we are taught to start planning for a patient’s discharge upon admission. Veterans often present increased challenges to discharge planning associated with the unique needs specific to that patient population. It is important to determine if the disability or disease process was service-related. For example, if a Veteran served in Vietnam in certain areas and periods of time or near the Korean demilitarized zones, the U.S. Department of Veterans Affairs (VA) presumes that they were exposed to Agent Orange (VA, 2015b). Veterans with certain diseases such as hypertension, arthritis, diabetes mellitus, and peptic ulcer disease or disabilities that appear within one year after discharge may be eligible for disability compensation. Veterans exposed to radiation, asbestos, or biochemical agents may also be entitled to disability compensation. Gulf War illnesses and Prisoners of War are often eligible for disability. The benefits available to Veterans are important to mention when providing hospitalized Veterans with education about available resources. Resource education should be taught upon admission, during the hospital stay, and at discharge. Unfortunately, getting Veterans the resources they need is more complicated than just providing education.

As a nurse in New Orleans, I have cared for numerous homeless Veterans living under the high-rise just blocks from the hospital. When working to provide clothes, food, and health care transportation to the homeless community, I have met many Veterans seeking and in need of resources. In addition, my church supports the Wounded Warrior Project by transporting disabled Veterans to medical services provided by a nearby parish hospital. The women of my church are also meeting many Veterans seeking and in need of resources. Resource education should be taught upon admission, during the hospital stay, and at discharge. Unfortunately, getting Veterans the resources they need is more complicated than just providing education.

As a nurse caring for a Veteran, it is important to establish effective discharge planning in an attempt to prevent homelessness. Homeless individuals are 3-6 times more likely to develop serious illnesses than people with adequate shelter (Fader & Phillips, 2011). Illnesses are often co-morbid and can include: physical, psychiatric and social problems, and substance abuse. Many Veterans seek emergency departments for care, which is both costly and inappropriate for ongoing medical conditions (Fader & Phillips, 2011).

There are legal issues relating to Veteran care for hospitals as well. Specifically, the revolving door syndrome—meaning Veteran patients who continue to seek medical care in the emergency department for non-emergent conditions—applies to all hospitals participating in the Medicare program. A federal law, The Emergency Medical Treatment and Labor Act (EMTALA), was established to ensure anyone coming to an emergency department is stabilized and treated, regardless of insurance status or ability to pay. However, since its enactment in 1986, the law has remained an unfunded mandate (ACEP, 2015). Hospitals and doctors that violate EMTALA are subject to fines of up to $50,000 (Fader & Phillips, 2011). In addition to stiff fines, violators may also be subject to civil lawsuits by patients for violations of the act.

The Medicare and Medicaid Patient Protection Act of 1987 is referred to as the Anti-Kickback Law. The Medicare Anti-Kickback statute prohibits (USLegal, Inc., 2015):

- Willful solicitation or receipt of remuneration in return for referrals of Medicare patients for any service for which payment may be made in whole
- Excluded from participation in Medicare & Medicaid programs
- Subject to civil lawsuits by patients for violations of the act
- Subject to prosecution by the Office of Inspector General of the Department of Health and Human Services

If you have any questions or comments regarding the “Legal Nursing” column, or if you are interested in writing, please contact Column Editor Helen P. Neil at hpneilm@cox.net.
or in part under Medicare or a state health care program
• The offer or payment of remuneration to induce such referrals

Nurses and hospitals must adhere to all regulations when planning a discharge. Discharging Veterans is often like putting a puzzle together. One piece of the puzzle is discharge planning – a process for identifying and organizing the services and connections a person with mental illness, substance abuse, and other vulnerabilities will need when leaving an institutional or custodial setting and returning to the community (Backer, Howard, & Moran, 2007). The goal is to discharge the patient to stable housing, ensure recovery, promote self-sufficiency, and increased quality of life. The legal obligation is to discharge the patient to a safe setting that provides respective care for their personal, cultural, psychological, and spiritual values. It is also important to adhere to the discharge policies and procedures specific to your facility. Documentation of all communication between patients, care coordinator, and discharge disposition is essential. It is also important to remember that the Veteran has the right to legal representation if he or she does not agree with the discharge disposition. Legal representative provides advice with patient right issues, such as:

• All issues pertaining to patient rights in hospitals, nursing homes, and home health care settings
• DNR, Health Care Proxy, and issues concerning the withdrawal and/or withholding of life-sustaining treatment
• Issues concerning behavioral units
• Nursing home resident right and discharge/transfer issues

In summary, ensuring a safe, appropriate discharge of Veterans can decrease the risk of legal action toward the staff and facility. The discharge team working together with the community and legal resources can ensure the most effective, self-sufficient, and independent disposition.

References

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A Sergeant’s Story
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served. I only want to talk about it with other people who have served. I’ve seen human wounds, blood, exposed bones.

I want nurses to ask me if I’ve served and to know that I’m a vet, but not make me share what I’ve been through. I also don’t want people to assume everyone who has served in the military has post-traumatic stress disorder (PTSD) either. We don’t want to be treated like we are freaks. It irritates me that there is such a focus on PTSD now, so everyone assumes we all have it. Many of my buddies are more aggressive after coming home from the war. Lots of guys start drinking more and they tend to want to fight more than prior to the war, but that’s not necessarily PTSD.

I am stateside now and will end my service to the Army in September 2015. I am engaged to be married and am planning to return to my small, quiet home in Holdrege, Nebraska, where I will farm with my Dad and brothers. I am proud of my service to my country and my time in the Army. I know we helped restore peace to very violent places in the world. I will remain friends with my Army buddies the rest of my life and will forever miss my friend, John. Well done, John. You are my hero. Rest in peace, buddy.

Gray N. Pearson is a Staff Sergeant, United States Army.

Disclaimer: The views expressed in this article are those of the author and do not reflect the official policy or position of the United States Army, Department of Defense, nor the U.S. Government.

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Las Vegas
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Highlights
• Energize your nursing knowledge
• Enjoy new friends and nurse colleagues
• Earn up to 15.25 CNE contact hours
Question: What are three of the most important nursing topics you'll be hearing about this year?

If you said, “Evidence-Based Practice,” “Clinical Leadership,” and “Care Coordination,” congratulations, you're on top of some of the most buzzed about initiatives happening in med-surg nursing (and AMSN!). You’re also going to be excited about the upcoming 24th Annual Convention, which puts these hot topics front and center.

What will you take home from the convention? Connections. Knowledge. Inspiration. Ideas that will help you branch out in ways you may not have imagined.

It's in the Evidence

The Opening Address of the convention, which will be held September 24-27, 2015, at the Paris Las Vegas in Las Vegas, NV, will be delivered by Vicki Hess, MS, RN, CSP, award-winning speaker and author. Ms. Hess will kick off the main program by teaching you how to use evidence-based tools and techniques to transform the way you work and inspire positive changes.

The next day, keynote speaker Linda Aiken, PhD, RN, FAAN, one of the country’s most influential nursing researchers and leaders, will delve into the deepest levels of nursing research and its impact on quality outcomes.

You’re a Leader

We’re human; sometimes we don’t see what’s right in front of us. So know this: if you’re a nurse, you’re a leader. To help empower you and develop your leadership skills, AMSN has launched a program specifically for bedside clinical nurses. At the convention, AMSN Past President Cece Grindel, PhD, RN, FAAN, will tell you more during her general session “Clinical Leadership: A Call to Action.”

This year’s Town Hall, always a convention favorite, will also focus on your role as a leader. Robin Hertel, MSN, RN, CMSRN, will host an interactive discussion, “The Clinical Leadership Challenge: A Town Hall Discussion.” Be sure to join the conversation!

And... The Hottest Topic Today

There’s not a nurse on earth who wants to see patients slip between the cracks in the health care system. That’s why we’ve included a general session to teach you about a key nursing role that’s getting a huge amount of industry attention: Care Coordination and Transition Management (CCTM). Mary Sue Dailey, APN-CNS, will help you understand the nurse’s critical role in helping patients transition seamlessly between health care settings.

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By attending the full 3-day convention, you will be able to earn up to 15.25 continuing nursing education (CNE) contact hours. We will also be offering the Medical-Surgical Nursing Certification Review Course on September 23-24 (13.75 contact hours for both days; pre-registration required).

How to Register

Please visit convention.amsn.org for complete information and to register online. Questions? Call 866-877-2676 or email amsn-info@amsn.org.