The existence of pediatricians in the armed forces, let alone pediatric graduate medical education programs, may come as a surprise to many in the civilian community, and perhaps to some in the military community as well. Yet the history of military pediatric residency training goes back well over 60 years, following and closely mirroring the broader evolution of pediatric graduate medical education in the United States.

Although the recognition of pediatrics as a distinct specialty in this country can be traced to the days of Abraham Jacobi in the latter part of the 19th century, the evolution of pediatric graduate medical education (GME) programs largely followed the establishment of the professional organizations that were formed to support the fledgling specialty. The American Academy of Pediatrics (AAP) held its first meeting in 1931, during which a committee was set up to consider the possibility of board certification. The American Board of Pediatrics was subsequently incorporated in 1933 to be made up of 9 members, 3 each from the AAP, the Section on Pediatrics of the American Medical Association, and the American Pediatric Society. In addition to its role in certifying individuals, the Board also included certification of training programs in its original charter, a role it shared until 1953 with the Council on Medical Education and Hospitals of the American Medical Association (forerunner of the Accreditation Council on Graduate Medical Education). Graduation from medical school, in addition to completion of a 2-year accredited pediatric residency after an internship of unspecified type, was one of the major board eligibility requirements. Although many of the first board-certified pediatricians were “grandfathered” into the examination because of the previous paucity of pediatric training programs, by the end of World War II the requirement for residency training was rigidly enforced and no further “grandfathering” took place.

The birth of pediatric residency training programs in the military followed little more than a decade after the creation of the American Board of Pediatrics itself. In the aftermath of World War II, an unfortunate population demographic had developed that would prove to have a direct influence on the need for pediatricians in the military. Specifically, the devastated postwar populations of Europe and Asia were left with a relative shortage of marriageable young men. This situation, combined with the presence of large numbers of young American soldiers and sailors who were now stationed in these countries, resulted in tens of thousands of “war brides.” These women, and their recently born children, were brought to the United States in troop transport ships in the early years following the war. The ships were poorly configured to maintain health and it quickly became apparent that crowding and poor sanitation placed these women and especially their infants and young children at serious risk for a myriad of infectious diseases.
Colonel Ogden Bruton, one of the few board-certified pediatricians on active duty in the Army at the time, was dispatched to Europe to study the problem of infant morbidity and mortality among the war-bride families and to determine how to more safely transport these children and their mothers back to the United States. Among his recommendations was the establishment of a 90-day pediatric course for Army general medical officers who were to be stationed overseas. Afterward, Dr Bruton was asked to develop a pediatric service and later a pediatric residency at Walter Reed Army Medical Center.

Following World War II and the demobilization of thousands of physicians, there was a huge demand for additional formal specialized medical training. As expected, the vast majority of physicians left the service to return to their civilian lives and thus sought their additional training in civilian programs. At the same time, the military saw GME as an avenue to attract and keep a cadre of already-serving military physicians who wanted additional training and were also inclined to the military lifestyle, as well as the opportunity to recruit new medical graduates to their programs. In addition, the establishment of a large peacetime military force, later enabled by the draft, had also begun in the aftermath of World War II. This expansion intensified the need for the military to train even more of its own doctors in an increasingly wider variety of specialties. Although GME programs in the form of rotating internships had existed in military hospitals since 1920, they were largely discontinued in the 1950s. After World War II, the Army and Navy both reestablished internships and a number of residency programs (Table 1) at their largest hospitals. The services made a commitment to train to board eligibility and the number of programs and trainees grew rapidly. The Navy opened training programs in 8 naval hospitals between 1946 and 1949 including Bethesda, MD; Long Beach, CA; Great Lakes, IL; Chelsea, MA; Oakland, CA; Philadelphia, PA; and St Albans, NY, with 265 trainees in these programs by 1948. In May 1946, the Army opened 49 programs that by January 1948 had grown to 71. Remarkably, there was no active-duty service obligation until 1951 when 1 year of active duty service following the internship was required. The first of these early military pediatric training programs was at Chelsea Naval Hospital in Massachusetts, which opened its pediatric residency in the fall of 1946 under the direction of Commander David Sherwood. Just 2 months later, then Lieutenant Colonel Leo J. Geppert, a World War II combat veteran, opened the Army’s first pediatric residency program at Brooke Army Hospital in San Antonio, TX. For several years after initiation of the programs, resident classes consisted of 1 resident per year. Hospitals were surveyed and programs granted full or limited approval, with the program at Walter Reed being the first military program to be fully accredited in 1947, followed by Brooke in 1949 and Chelsea in 1950. According to Dr Geppert, there were fewer than a half-dozen qualified pediatricians in the Army at this time; pediatrics, like many of the other specialties, turned to the extensive use of civilian consultants, many of whom had served on active duty during World War II, to assist with their programs until the number of board-certified physicians on active duty could be increased.

On June 25, 1950, North Korean forces invaded South Korea across the 38th parallel and within 3 days had occupied and taken control of Seoul. As the Army’s only source of quickly available medical officers, 230 residents were removed from their training and within days flown to Korea. The same was true of the Navy, whose residents became medical officers serving with Marine forces on the ground and afloat on several hospital ships. After the war, most of these physicians returned to complete their training. The Korean War was the only situation where large numbers of residents were deployed out of their training for contingency operations. The US Air Force was born from the US Army Air Forces in 1947. It took several years for the construction of medical facilities and the development of medical services to the point they could

### Table 1: History of Military Pediatric Residency Programs

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
<th>Program Opened</th>
<th>First Chief and Program Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea (MA)</td>
<td>Navy</td>
<td>November 1946</td>
<td>David W. Sherwood</td>
</tr>
<tr>
<td>Brooke (San Antonio, TX)</td>
<td>Army</td>
<td>January 1947</td>
<td>Leo J. Geppert</td>
</tr>
<tr>
<td>Oakland (CA)</td>
<td>Navy</td>
<td>July 1947</td>
<td>Milton Kurzrok</td>
</tr>
<tr>
<td>Walter Reed (Washington, DC)</td>
<td>Army</td>
<td>July 1947</td>
<td>Ogden Bruton</td>
</tr>
<tr>
<td>National Naval Medical Center (Bethesda, MD)</td>
<td>Navy</td>
<td>July 1948</td>
<td>Thomas T. Fowler</td>
</tr>
<tr>
<td>Fitzsimons (Aurora, CO)</td>
<td>Army</td>
<td>July 1948</td>
<td>Frederick Simpson</td>
</tr>
<tr>
<td>Philadelphia (PA)</td>
<td>Navy</td>
<td>July 1949</td>
<td>Thomas E. Cone</td>
</tr>
<tr>
<td>Portsmouth (VA)</td>
<td>Navy</td>
<td>July 1948</td>
<td>Frederick Becker</td>
</tr>
<tr>
<td>Letterman (San Francisco, CA)</td>
<td>Army</td>
<td>July 1948</td>
<td>Walton M. Edwards</td>
</tr>
<tr>
<td>San Diego (CA)</td>
<td>Navy</td>
<td>July 1957</td>
<td>Ernst Moeller</td>
</tr>
<tr>
<td>Tripler (Honolulu, HI)</td>
<td>Army</td>
<td>July 1957</td>
<td>Ogden Bruton</td>
</tr>
<tr>
<td>Madigan (Tacomca, WA)</td>
<td>Army</td>
<td>January 1958</td>
<td>Edward J. Tomsovic</td>
</tr>
<tr>
<td>Wilford Hall (San Antonio, TX)</td>
<td>Air Force</td>
<td>July 1958</td>
<td>Thomas M. Holcomb</td>
</tr>
<tr>
<td>David Grant (Fairfield, CA)</td>
<td>Air Force</td>
<td>July 1966</td>
<td>Kenneth Shepard</td>
</tr>
<tr>
<td>Keesler (Biloxi, MS)</td>
<td>Air Force</td>
<td>July 1969</td>
<td>Frederick R. Stowe</td>
</tr>
<tr>
<td>Wright Patterson (Dayton, OH)</td>
<td>Air Force</td>
<td>July 1978</td>
<td>Christian Y. Herrara</td>
</tr>
</tbody>
</table>
support GME. The first Air Force pediatric training program was established at Wilford Hall Air Force Medical Center in San Antonio in 1958. As one of the program’s original architects, renowned educator Colonel Howard Johnson would go on to become the program director and department chair for the better part of the next quarter century, training scores of Air Force pediatricians.

The services began sponsoring physicians to fellowship training in civilian programs in the 1950s. It is difficult to determine for certain when the military began to offer fellowship training in its own facilities; however, an announcement in the October 1967 newsletter of the AAP Section on Military Pediatrics states that Colonel Fred Biehusen, then chief of pediatrics at Walter Reed, offered 4 third-year fellowships in pediatrics (the standard duration of pediatric residency training at this time was 2 years). The 12-month fellowship consisted of four 3-month rotations: genetics and developmental diagnosis, renal-metabolic problems, adolescent medicine, and mental retardation and community relations. Specialty fellowship training evolved primarily from the requirements of the military to staff their pediatric residency programs with high-quality career-oriented subspecialists, as well as to fulfill the clinical needs of the expanding military pediatric beneficiary population. In the 1970s and 1980s, specific pediatric fellowships in military hospitals were developed in adolescent medicine, developmental pediatrics, hematology-oncology, infectious diseases, allergy and immunology, neonatology, endocrinology, and gastroenterology, as well as other subspecialties. Some were short lived, as they were dependent on a small number of subspecialty-trained staff, sometimes only 1 or 2, whereas close to a dozen still operate today as fully accredited and nationally recognized programs more than 30 years after being established. With the onset of military force reductions begun in the 1990s, each of the 3 services began to coordinate assignment of their specialists with each other, with many of the larger medical centers now increasingly staffed by personnel representing a cross-section of all 3 military branches.

With the termination of the physician draft during the closing years of the Vietnam War, the challenge of maintaining an adequate supply of qualified and competent physicians to serve the vast military beneficiary population was met by 2 landmark decisions that would ensure not only the survival of military graduate medical education programs, but indeed their significant growth: the establishment of the Armed Forces Health Professions Scholarship Program (HPSP) and the creation of the Uniformed Services of the Health Sciences.

The HPSP was created under authority of the Uniformed Services Health Professions Revitalization Act of 1972. Prospective medical students at civilian medical schools were to apply for these scholarships through 1 of the 3 military services—Army, Navy, or Air Force. If selected, they would be commissioned as second lieutenants in the Army or Air Force, or as ensigns in the Navy, and receive reimbursement for all tuition, books, and supplies, as well as a monthly stipend. On graduation from medical school, the overwhelming majority have entered military residency programs, and their service obligation—generally 1 year of service for each year of medical school support—would usually begin after their residency training. Most residents and fellows in military programs over the past 3 decades have come from this pool of students.

The training of active-duty pediatric residents at military medical treatment facilities has a long history. A list of current military pediatric graduate medical education programs can be found at: http://www2.aap.org/sections/uniformedservices/GuideToMilitaryPediatricResidency.pdf

Over the years, the Navy programs at Chelsea, Oakland, and Philadelphia; the Army programs at Letterman (San Francisco, CA), Fitzsimons (Aurora, CO), and William Beaumont (El Paso, TX); and the Air Force programs at David Grant (Travis Air Force Base, CA) and Keesler (Biloxi, MS) were closed secondary to military decisions regarding manpower needs or closure of military bases.

In April of 1985, however, the long-standing independent programs at Walter Reed and Bethesda Naval Hospital were integrated to form the first combined pediatric residency program in the country: the National Capital Consortium Pediatric Residency Program. Although hospital mergers were not infrequent during this time for economic reasons, the decision to merge these 2 historic residency programs was not primarily fiscal, but rather based on educational optimization and consolidation of resources. More than 10 years later, the congressionally directed Base Realignment and Closure Committee recommended closure of the Walter Reed Army Medical Center and integration of all its clinical and educational activities to a newly renovated and expanded facility on the grounds of the Bethesda Naval Hospital. This new facility, the Walter Reed National Military Medical Center, is fully functional as of September 2011, with the subsequent unification of pediatric, as well as other clinical activities, into the first tri-service medical center in the Department of Defense Health Care System.

For reasons similar to those that led to the integration of GME programs in the Washington, DC, area, in 1996 the pediatric residency programs at
Brooke Army Medical Center and Wilford Hall Air Force Medical Center, both in San Antonio, TX, were merged to form the San Antonio Uniformed Services Health Education Consortium Pediatric Residency Program. Likewise, the Base Realignment and Closure Committee in 2005 also recommended integration of most of the clinical and educational activities at Wilford Hall into a newly expanded facility on the campus of Brooke Army Medical Center, to be known subsequently as the San Antonio Military Medical Center. Like the new facility in the national capital area, this facility is now fully operational as of September 2011.

In addition to maintaining the standards set forth by external accrediting bodies, such as the Accreditation Council on Graduate Medical Education and the Pediatric Residency Review Committee, today’s military programs have continually evolved to incorporate “military-unique” aspects into their curricula as well, to include courses in combat casualty care, trauma support, tropical medicine, and disaster and humanitarian assistance medicine. As the role of military medicine has continued to expand beyond the care of sick and injured service members and their dependents, to the care of displaced and underserved populations around the world, so too have the opportunities for resident and fellowship education in international settings expanded, from experiences overseas on board Navy hospital ships to rotations in the developing world, where trainees work to effect positive public health outcomes within local communities.

Since their inception in the late 1940s, military pediatric GME programs have been recognized for their excellence and innovation, and have produced graduates who have gone on to leadership positions throughout the military and civilian medical communities. As their collective history enters its seventh decade, the existing programs continue to graduate dozens of new military pediatricians and subspecialists each year, adding to the hundreds already trained before them, and continuing to build on their long and storied legacy.

**PEDIATRIC UNDERGRADUATE MEDICAL EDUCATION**

Congressman Felix Edward Hébert from Louisiana understood the importance of preserving, maintaining, and enhancing the science and art of military medicine. As chairman of the US House of Representative’s Committee on Armed Services, he believed that this could best be done by the establishment of a “military school of medicine.” Through the efforts of Congressman Hébert and others, the Uniformed Services University of the Health Sciences (USUHS) was founded in 1972, the same year as the creation of the HPSP program. It is noteworthy that the “all-volunteer” US military was established at the same time as the all-volunteer professional military medical services. Together, the all-volunteer Army, Navy, Marines, and Air Force have developed and evolved concurrently with an all-volunteer force of physicians, nurses, military public health practitioners, medical support practitioners, pharmacists, laboratory professionals, and military medical researchers. The development of the military medical university provided and continues to provide an intellectual, scholarly, and educational home for the unique discipline of military medicine. The F. Edward Hébert School of Medicine at the USUHS in Bethesda, MD, matriculated its first medical students in 1976.

The establishment of the Department of Pediatrics was part of the initial educational mandate concurrent with the founding of the medical school in 1972. Colonel James W. Bass, a nationally recognized pediatrician, researcher, and scholar, was appointed as chair. The Department became the first formal center for academic Pediatrics in the Department of Defense health care system. The faculty assembled by Dr Bass included a number of pediatric subspecialists whose responsibilities, in addition to clinical services and teaching, included laboratory and clinical research. Receiving provisional Liaison Committee on Medical Education accreditation in 1976 and remaining fully accredited since 1979, the USUHS Department of Pediatrics has been instrumental in the education of more than 4400 USUHS graduates.

The Department of Pediatrics saw its first class of medical students rotate through the third-year pediatric clerkship in 1979. The clerkship was 6 weeks long and students rotated through Army, Air Force, and Navy facilities. All 3 clinical teaching sites at that time were located within the national capital area. Then, as now, students rotating through the clerkship spent time on the pediatric wards, outpatient clinics, and in the newborn nursery. Over the years, the clerkship expanded and now includes 7 sites in Washington, DC, Virginia, Maryland, Texas, Washington State, California, and Hawaii. Fourth-year students have the opportunity to gain additional pediatric educational experience at sites worldwide, which offer a broader view of real-world military pediatric practice. To complement these direct-care experiences, USUHS is also home to a world-class simulation center that third-year clerks use to interview, examine, and educate a variety of standardized patients. Overseeing all of this activity during the third-year clerkship, in addition to participating in the first-year medical interviewing course, the second-year clinical reasoning course, and fourth-year...
pediatric clinical electives, is the USUHS Pediatric Education Section, which continues to be very actively involved with the Council on Medical Student Education (COMSEP), having aligned the third-year clerkship with COMSEP’s national curriculum.

Over the years, the Department of Pediatrics has been recognized for being at the forefront of pediatric undergraduate medical education in a variety of areas, including pioneering the use of a series of pediatric clinical teaching cases that eventually evolved into the national curriculum used by COMSEP known as the Computer-assisted Learning in Pediatrics Program, the creation of a multistation clerkship orientation program, the development of computer-generated pediatric clinical cases for third-year clerks accessed through USUHS-issued laptop computers, the use of day care centers and high school students to teach second-year students pediatric physical examination techniques, as well as the psycho-social (Home, Education/employment, peer group Activities, Drugs, Sexuality, and Suicide/depression, more commonly known as HEADSS) interview, the introduction of a now nationally disseminated environmental medicine curriculum for pediatric clerks, the development of direct observation tools for students to learn professional behaviors and clinical skills, and the implementation of a pediatric home visit initiative for medical students, paired with a reflective writing exercise. These innovations, among others, have resulted in the department’s recognition as the only third-year clerkship in the country to twice win the Academic Pediatric Association’s Outstanding Teaching Award.

What makes the USUHS Department of Pediatrics inherently different from its counterparts at civilian institutions, however, is its active involvement in the medical school’s military-unique curriculum, which adds nearly 700 additional hours of instruction to the standard curriculum of most civilian medical schools. Military physicians, regardless of their specialty, frequently find themselves in circumstances where they need to treat children, often in austere conditions that are present in times of war or humanitarian assistance deployments. Recognizing this reality, pediatric faculty at USUHS have been key advocates for the inclusion of pediatric-specific content into the medical school’s military-unique curriculum, which, among other aspects, includes 2 very unique medical exercises.

Operation Kerkesner is a field exercise that takes place at Ft Indiantown Gap, PA, between the first and second years of medical school. During this exercise, students learn a variety of skills, from land navigation and “care under fire” to survival training and Tactical Combat Casualty Care. They spend 3 weeks in field conditions, much as they might find in the early phase of a deployment. During the second half of this exercise, the students learn about being “patients” by simulating symptoms, receiving realistic moulage for various injuries, and acting as the ill and injured for the students in Operation Bushmaster.

Operation Bushmaster is the capstone course for the military-unique curriculum and takes place between the student’s third and fourth years. The first dean of USUHS, Dr Jay Sanford, stated that the goal of Operation Bushmaster was “To prepare the graduate to serve successfully, following internship, as a general medical officer in the emergency room of a fixed military medical facility or as a general medical officer at the forward-most point on the modern battlefield at which physicians are positioned.” Before heading into the “field,” students receive numerous hours of classroom instruction, including the complete advanced trauma life support certification course. Once in the field, students are evaluated not only on their medical knowledge, but also their leadership attributes, communication skills, and military professionalism. Their final and most challenging scenario is a nighttime mass casualty exercise that requires the entire class to function as an efficient team (Fig 1).

From academic innovation and excellence in pediatric education and research, to its integral role in the military-unique curriculum of the medical school, the Department of Pediatrics at USUHS continues to function as the academic home for the more than 600 active-duty and civilian pediatricians working for the Army, Navy, Air Force, and Uniformed Public Health Service Corps. The “proof of concept” of F. Edward Hébert’s home for military medicine has been amply validated since 1972 and in the recent US involvement in wars in Iraq and Afghanistan, as well as in humanitarian engagements worldwide. As the nation’s only federal medical school enters its fourth decade, USUHS not only continues to execute its core mission of “caring for those in harm’s way” through the training and preparation of past, present, and future military medical providers, but also continues to reflect and improve on that mission, both at home and abroad, and in both children and adults.

EPILOGUE–THE LEGACY

As a testament to the sustained contributions of military pediatrics to the quality health care of American children, to celebrate the 50th anniversary of the Section on Uniformed Services of the AAP, and to recognize more than 60 years of pediatric graduate medical education, in 2009 the AAP published A Fifty-Year Legacy of Service to
Uniformed Pediatricians and the Children and Families They Serve. The book documents the contributions to American and military dependent child health by dozens of outstanding military clinicians, teachers, clinical and basic science researchers, administrators, and leaders. Although it is risky to mention some, at the risk of excluding others whose contributions are no less worthy, we have included some excerpts from this text that mention a few of the notable figures in military graduate medical education over the years (Fig 2).

An ordinary moment in 1957 becomes an extraordinary photograph, not for the events of that moment, but for the accomplishments of the individuals pictured and its reflection through more than 50 years of the contributions of military medicine and military pediatric graduate medical education. Left to right are, Captain Tom Cone, Chief of Pediatrics at Bethesda Naval Hospital; a child whose name and future are unknown; Lieutenant Howard Pearson, a resident in pediatrics; and Commander Charlie Waite, assistant chief of pediatrics at Bethesda.

Dr Tom Cone was the first program director of the pediatric residency program at Philadelphia Naval Hospital in 1949. He was chief of pediatrics and
program director at Bethesda from 1953 to 1963. He retired from the Navy in 1963 and went on to become a clinical professor of pediatrics at Harvard and then professor emeritus of pediatrics. His T.E.C., Jr. historical notes appeared well over 400 times in Pediatrics. He was the sole author of the *History of American Pediatrics*, published by Little, Brown and Company in 1979, often cited as the first comprehensive text on the subject. In 1985, he published *200 Years of Feeding Infants in America*. For many years, he was an editor of *A Manual of Pediatric Therapeutics*.

Before his pediatric residency, Dr Charlie Waite had interned at Bethesda and volunteered for submarine duty. After he completed Navy diving school at the Washington Navy Yard and the Navy submarine course in New London, CT, he was assigned as the medical officer of a submarine squadron in San Diego, CA. Following this assignment, he completed his pediatric residency at Children’s Hospital, Washington, DC. After his residency, he served as chief medical officer of an underwater demolition team during the Korean War.

His assignments then alternated between being a pediatrician, serving at Navy hospitals in Bethesda, Jacksonville (FL), Philadelphia, and Portsmouth (VA), and serving as a submarine medical officer. He was the first commanding officer of the Submarine Medical Center in New London, where he was a pioneer in the testing of the Aqua-Lung and other experimental diving gear and collaborated with Jacques Cousteau in the Navy’s underwater SEALAB habitat experiment. After promotion to Admiral, he served in the Pacific and in Washington, before his retirement, he was Deputy Surgeon General of the Navy.

Dr Howard Pearson completed his pediatric residency at Bethesda and a hematology fellowship at Boston Children’s Hospital. He then served on the pediatric staff at Bethesda as assistant chief of pediatrics from 1958 to 1962. Following his Navy service, Dr Pearson entered full-time academic pediatrics and ultimately became chair of the Department of Pediatrics, Yale School of Medicine, and chief, pediatric service, Yale-New Haven Hospital, both from 1974 to 1987. Although he is most well known for his groundbreaking work on sickle cell disease and thalassemia, he has made significant contributions to our understanding of a wide range of other childhood hematologic conditions as well. From 1993 to 1994, he served as president of the AAP. Dr Pearson is currently professor emeritus of pediatrics at Yale School of Medicine.

Colonel Ogden C. Bruton is shown (Fig 3) with resident Bart Ramsey in the 1950s. Dr Bruton started the pediatric residencies at Walter Reed in Washington, DC (1947) and Tripler Army Medical Center in Honolulu (1955). He is well known for reporting the first-ever case of an immune deficiency disease in a child he was following at Walter Reed; Bruton’s disease is also known as X-linked agammaglobulinemia.
of the Section on Military Pediatrics, Dr Scherz is perhaps best known for his pioneering work on poison control and accident prevention. His seminal research in the 1960s led to the development of an effective child-resistant prescription container, and his advocacy on behalf of child safety issues was instrumental in the passage of the Poison Prevention Packaging Act of 1970. In addition, his research on the use of child safety restraints provided objective verification that such systems prevent death and injury to child passengers in automobiles, leading eventually to current child-restraint laws now in place throughout the country. Dr Scherz went on to become the chairman of the AAP Committee on Accident and Poison Prevention, as well as president of the American Association of Poison Control Centers.

Colonel Val G. Hemming (Fig 6) completed his pediatric residency training at Wilford Hall Air Force Medical Center in 1968, followed by a 4-year overseas assignment as a general pediatrician in Germany, and a subsequent infectious disease fellowship at the University of Utah. He was later assigned to Travis Air Force Base in California where he rose to become pediatric residency program director as well as pediatric department chair. Following assignment to the USUHS in 1980, he and others began laboratory and clinical investigations that would ultimately lead to the development of antibody prophylaxis for respiratory syncytial virus infection in high-risk neonates, which is now in wide use today around the world. Dr Hemming would later become chair of the Department of Pediatrics, and eventually dean at the medical school.

Colonel James W. Bass (Fig 7), who also received his pediatric training in the military, would eventually go on himself to train nearly 150 pediatric residents, more than 20 fellows in pediatric infectious disease, and countless medical students, nurses, and other health professionals as residency program director, department chair, and head of the infectious disease fellowship at Tripler Army Medical Center. He was
also the first pediatric department chair at the USUHS. In addition to his well-known teaching and administrative abilities, Dr Bass was a true giant in the field of pediatric infectious disease with well over 200 publications in a variety of different areas. He was the first to demonstrate the usefulness of erythromycin in the treatment of pertussis, showed that streptococcal pharyngitis could be treated with oral penicillin twice a day, discovered that the cat-scratch disease organism could be found in kittens in Hawaii, proved the usefulness of the antibiotic azithromycin for cat-scratch disease treatment, and developed the protocol used nationwide for the treatment of infants and children with fever and suspected bacterial infection. A member of the prestigious Red Book Committee of the AAP, he received numerous awards throughout his lifetime including the very first “Burtis Burr Breese Award” for outstanding research, teaching, and practice in pediatric infectious diseases; the Pediatric Infectious Diseases Society Distinguished Physician Award; the Lewis Aspey Mologne Award for Academic Excellence; and the Outstanding Service Award from the Section on Uniformed Services of the AAP. Perhaps his greatest legacy is the many physicians he trained who currently and in the past have served as leaders in pediatrics and medicine.

Although these pioneers comprise an important part of the military pediatric GME legacy, they are but a few of the many military pediatricians who have contributed both to graduate medical education and to the science of child health and nutrition over the years. New leaders, teachers, scientists, and administrators have and will continue to emerge, some likely to exceed the excellence of their predecessors. The breadth of their training and their unique skills will make them valuable members of the medical community that practices the disciplines of military medicine, and their commitment and skills will continue to enhance the lives not only of those children and families within the military, but the larger pediatric community as well.

REFERENCES

5. Pierce JR. A Fifty Year Legacy of Service to Uniformed Pediatricians and the Children and Families They Serve. Elk Grove Village, IL: The American Academy of Pediatrics; 2009
Pediatric Medical Education in the United States Military
John R. Pierce, Val G. Hemming, Martin G. Ottolini, Joseph O. Lopreiato and Clifton E. Yu

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