

Physician Assistant Section

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Tops on the agenda is readiness. Individual PAs must be certain they have their family matters squared away, especially the PROFIS PAs. As this letter goes to print, we are all heavily involved in SRPing our troops. From this level, I hear about all the problems -- the soldiers who have not had immunizations, medical evaluations, or eyeglasses and meds. Most of these problems arise with the RC compos being activated, but there are also incompletely prepared AD. Keep on top of your soldier readiness.

The new IPAP class, which began January 6th, will be the first class where students are earning masters'. Those students will be awarded a baccalaureate at the end of Phase I here at the Schoolhouse and receive a master's at the completion of Phase II and all course requirements. For the extra degree they are being required to do additional work. Students now take several classes on writing and exploring research which will culminate in a final paper written at the end, much like the current University of Nebraska distance learning program.

AER 40-20 became effective in Germany in December. This regulation, written by AMEDD personnel, was published by the Army in Europe. The regulation is significant in that it specifies quality control measures and practice limitations in BASs. This is the first such regulation on this topic I am aware of. It does not change the status of not reporting BAS workload, but reflects AMEDD control of garrison medical care. The regulation arose out of three bad outcomes in Germany which occurred in BASs. Currently the Division Surgeon is serving as the intermediary for policy negotiation between the MTF and battalions. The point of this issue is that PAs must police themselves in this myriad of patient care. The care is not recorded in the AMEDD reporting system, nor is it performed in an approved facility. However, the MTF commander is nonetheless responsible. Where control is not clear, there is no license to ignore quality of care standards. You must be certain that everything is documented on the patient record. It may take an extra minute to make all the notations, but you will appreciate the effort when you're talking to a judge. Medic work must be supervised. PAs love to have medics work in the BAS. It's difficult to get medics to the MTF, and frequently they encounter restrictive policy which prevents them from training to their full scope of practice (another issue). Training them is critical to what I call "the PA-Medic team". Not unlike the surgeon and the surgical nurse team, AMEDD team members must train together to their full scope of practice. Training leads to mission readiness. Ninety-nine percent of all medical evacuations during combat are for DNBI -- not combat related. Thus, medics must get to see patients, work out the complete SOAP-P process, and be given feedback by the supervising provider. You must take the time to do this. If you don't, medics will not learn the critical thinking skills and gain the clinical experience to prevent the DNBI that will make the soldier mission ineffective.

The PA Refresher Course has just been completed under the expert direction of CPT Engelhard. In addition to the resident course, a VTT for four hours on three consecutive afternoons, was broadcast to 217 sites, CONUS and OCONUS. I hope you all took advantage of the opportunity to attend some of the lectures. The CME CD is currently being developed, and you will be notified when it is available. The resident course, VTT, and CD are all accredited for Category I CME. Under the direction of LTC Kuwamoto and MAJ Albert at DHET, a program of monthly CME development is being planned to go year round so that we can keep supplying CDs with updated material.

Another way I plan to supply medical education is through the quarterly VTCs. I am disappointed at the attendance for PA VTCs. This year the VTC will have a lecture included, minimizing the administrative talk. On February 12th, MAJ Hernandez from Nutrition Care will present a brief lecture on performing nutritional assessments in large camps of displaced persons. I have found this information totally new and vital to our extra mission taskings. In March, CPT Montz of Occupational Therapy will discuss the Combat Stress Control units and how they interface with the PAs and BASs. Again, this is a new and important topic. There are still two VTCs remaining to plan this Fall. Please send me some ideas on topics that you would like to hear, and I will add them to the agenda.

Manpower projects I am working on include gaining positions for 65DM3, APAs, to replace 61N, Flight surgeons, as well as gaining a Neurosurgical residency for PAs trained in orthopedic surgery. Replacing 61Ns in aviation battalions should result in 20 or so positions for APAs. Training for Neuro PAs will be much smaller as there is only a need for 2-4 to assist in a few locations. There is still no indication of an opportunity to start a general surgery PA residency, but I keep my ears open for the chance.

Resolution of the requirement for PAs to get licenses is continuing. The letter to all the state medical boards was sent from DODHA two months ago. DODHA confirmed that about one-third of the states have responded, but the replies have not yet been reviewed. The outcome could go one of two ways. If there are enough states that will grant valid, current, and unrestricted licenses to federal PAs, then PAs will be required to obtain a state license. If there are not enough states willing to license federal PAs, then we will request a waiver for federal PAs from DODHA. As soon as we know more about the states' responses, I will notify you of the results and planned outcome.

February 4th is the 11th anniversary of PA commissioning. In retrospect, I believe that this was a very positive move forward for PAs. PAs are pivotal in providing significant input to military health care. Rank equates with credibility, and even though our rank is generally behind our peers, based upon our experience, I believe that we now get more consideration from the AMEDD.

Reserve PAs will finally have an officer in the AMSC office. The other AMSC branches have had IMA officers drill with the branch chiefs. The IMAs provide a strong connection between the compos. Last fall I identified an IMA possessing extensive AD, reserve, and VA backgrounds. LTC James Shear was put on orders as the DIMA

(Drilling Individual Medical Augmentee) for my office. I plan to bring him on board as soon as I can for a two-week drill and then assign him projects to be completed during his individual drills at home. One of our big challenges is getting PA field training and education to reserve PAs. Reserve PAs of all compos are now being called up and are performing outstanding service alongside their AD peers. I want to better prepare them for deployment and mission medical requirements unique to the Army. LTC Shear will be a big asset in that mission.

I recently asked you to send in examples of preventive programs you had completed in the last year. I got a good response and was pleased to see all the different prevention programs you are doing in your community. A lot of PAs are giving classes on tobacco cessation, weight control, and conducting health fairs. One unique project provided classes to soldiers' spouses on the use of over-the-counter meds. We have a lot of young families in the military community, and they are now having to learn how to take care of themselves. All these projects improve the health of Army members and support mission readiness.

Finally, please keep in touch, even if you get deployed. E-mail me at any time, or call for any reason. I enjoy hearing from each of you.

Thanks again for taking care of the soldiers and their families.