

Chief, Physician Assistant Message

*COL William Tozier
Chief, Physician Assistant Section*

Last time I thanked you all for doing such a fine job. Now it appears you may be doing too good a job. We are about to have a significant increase in the budgeted end strength (BES) for PAs. This is at a time when the AMEDD is being asked to give up 3514 positions so the Army can grow more combat arms Soldiers.

Starting with the 3ID, and the modularity or brigade transformation into Units of Action, (UA), 144 new 65D positions are being added to the Army. These new positions are projected to be developed over the next three years. That is a big bill to fill that will require several different approaches to keep these new positions filled.

I have already requested and been granted an increase in the number of students attending the Interservice PA Program (IPAP). We have been sending 55 students a year through the program and will be increasing to 65 students. However, that change will take almost three years before the new graduates are practicing. In the meantime, we will get permission to open up active duty (AD) positions to PAs from outside. It is not clear who will be allowed to apply, but if you know of any PA who wants to come on AD, have them contact me or MAJ Balsler.

What makes this process more difficult is the speed with which it is happening. I just found out about the increase a couple months ago. Normal documentation of these new positions is not occurring before the requests are being forward to Human Resources Command (HRC) to be filled. Without the documentation, the target need is difficult to visualize and demonstrate. More importantly, other sections of the AMEDD manpower and personnel systems cannot react to support the "projected" increase of PA positions.

The downside is that this means I have no discretionary or unauthorized assignments available. I have had to turn down at least 4 requests from PAs to take command opportunities, as I needed to fill unit positions. I ask your patience during these times.

PA Readiness and Recertification Preparedness Symposium

CPT Archer continues to work on this years symposium. The dates this year will be November 1-5. We moved the time to avoid the rotation of OIF/OEF units that now tends to occur in March. We again plan a resident course, a televideo broadcast, and plan to produce another CD.

Category 1 CME CDs

As you may remember, we have touted the benefits of our Annual PA Readiness and Recertification Symposium as spreading beyond those funded to attend. In addition to the resident lectures and televideo presentations, a CD was created in 2002 and now in 2004. These CDs are available for you to get CME while

deployed or a location where attending conferences is difficult. MAJ Anne Albert has included the following instructions on how you can obtain the CD that is currently available, as well as the new CD coming out this summer. She said to note that we are not certain how long the contract with Swank Health will continue, so if you are not successful that route, use the ATRRS site. Also, the course numbers of the CDs may change, but the directions to find them should remain the same. Currently, 17 hours of category 1 CME are available and in the next few months there will be another 30 hours. I want to thank CPT Archer, MAJ Albert, and LTC Kuwamoto for all the work they have done to make these CDs possible. I hope you will find this useful in keeping your knowledge current.

Instructions for CD-ROM PA Recertification Course

ATRRS

1. Type in the URL <https://www.atrrs.army.mil>
2. On right hand of screen find ATRRS CHANNELS
3. Under ATRRS Channels find and click on **Self Development**
4. Click on **Continue to Self Development**
5. Fill in required information on the log in screen (SSN & Date of birth)
6. Under find a course either type the information or use the pull down tab **6H-A0626-CD Physician Assistant Read & Recert Pre Symp**
7. Hit enter
8. Click on course number
9. Click on Class 201—This is the 1st CD produced
10. Continue to fill-in the required information and follow the screen instructions

This is an application for the CD-ROM and it will be ship to the user. This similar the correspondence courses.

On-line Swank Health

1. Type in the URL <http://www.swankhealth.com>
2. On the left hand side of the screen find **Military Healthcare Service**
3. Under Military HealthCare Services click on **Homeland Security Courses/C.B.R.N.E.**
4. Scroll down to **Readiness Training/CE/CME Courses**
5. Click on **Physician Assistant (PA) Recertification 2002 Interactive Training**
6. Click on **Users Start Program**

Death Certificates

Currently no policy exists authorizing PAs to sign death certificates. However, it is important to remember that most MEDCOM policy is based upon the CONUS MTF environment. There is guidance regarding medical care and death for detainees and EPWs in AR 190-8. The policy of who may sign death certificates is being examined at OTSG, but I do not have any indication what it may conclude. In the mean time, I encourage those of you asked to sign a death certificate to get a physician countersignature. I will add that OTSG is currently involved in a Tri-service effort to develop guidance for detainee health care including an ethics portion. When that becomes available, I will be sure and send it forward.

The Surgeon Generals 2004 PA of the Year Award

CPT Christopher Van Winkle, C Company, 82nd Forward Support Battalion, 3rd Brigade, 82nd Airborne Division, Ft. Bragg, received TSG PA of the Year annual award. There were almost three times the number of nominations from unit commanders. The outstanding performance of PAs was detailed in the narratives of these nominations. I want to commend all those who were nominated. Reading the nominations was an incredible experience of selfless duty and remarkable professionalism.

Notes from the Field

Note from the MAJ Myslenski, Connecticut ARNG,

I am with HSC 118th Med BN (AS), one of three PA's in our company, one RN (all here for 1 year), plus 3 90-day rotational Docs and 90-day rotational dentist. We have one x-ray tech, a crude machine, and no Lab. Other units have come to use space in our clinic which allows us to have an optometrist and physical therapy. BN has PM and Mental health.

We are the Connecticut National Guard. A PA, CPT Michael McMahon is with us. He and I were deployed with the Connecticut Guard to Bosnia for SFOR 10 and were there on Sept 11, 2001. We were home about 18 months and were called up for this. We expected OIF II to be similar Peacekeeping type of mission, as was Bosnia.

This has been far more challenging and stressful. As a Corps asset, we see 100 plus patients per day on sick call and follow up. We run the LSA Anaconda, Balad, TMC. Our medics staff the Camp ERC vehicle. (emergency response center) There is a CSH on base, but since we do all immunizations, sick call, and most of the medical on base, I find frequently that soldiers on convoy that get hit by IED's enroute, that do not require helicopter transport, roll in the gate and come straight to us, not the CSH. I think they see us as their contact point for medical care, and let us decide if they need evaluation by the CSH. It's a compliment to us, and so far we have managed all of them. We have had 2 bad mortar/rocket attacks just outside our door, as we are located across from the

PX. Many injured soldiers and KBR workers, a real eye opener for many of us and our medics, that people are getting hurt and killed not only "out there" but also "in here". Of our BN, one of our other companies had a PA injured in a mortar attack, I heard that there was another PA was injured someplace, not sure of the unit, so 2 that I know of.

There are several units with PA's here on post, we are trying to network, meet and help each other as best as possible. This deployment has been somewhat of a PA "reunion" of sorts for me. As I said earlier, CPT McMahon and I were in Bosnia 2 years ago.

On my arrival to Kuwait I ran into Major Anthony Labadia, Florida National Guard, he was returning from OIF I. We were in the Connecticut National Guard together. I crossed paths with CPT John Elliot. He is with the 82nd Airborne and had just been to Afghanistan prior to OIF. We were junior enlisted medics together in the 3rd Infantry Division, 1987 Germany. CPT Dennis Hays was here on Anaconda with the Stryker Brigade, 2nd Infantry Division, we were Army PA Students together 10 years ago.

As I look back on all of this, I realize how small of a PA community we are. There are so many of us are here, during this time. I am happy to see so many old and new friends. I hope that everyone returns home safe and sound to their families and communities. I am certain that they are dearly missed.

Major Michael Myslenski,
SP, PA-C
HSC 118th Med BN (AS)
LSA Anaconda, Balad, Iraq

Note from CPT Sallaway, Massachusetts ARNG

I was activated 7 Dec 2003 and spent two months at Fort Drum with A Co. 118th ASMC, a National Guard Unit from Massachusetts. No one was quite sure what we were going to experience. I am assigned to A Co. But I do not drill with them. CPT Cavanna, LT. Dupuis and myself, Captain Scot E. Sallaway were unknown to the unit. The only good thing about the time spent at Fort Drum was that I really got to know the men and women of the unit. As an AMSC we provide echelon I and II level of care. We have a treatment team, ambulance team, lab, x-ray, holding, and headquarters. The medical care can be divided into three areas, illness, war wounds and ortho.

We arrived in Kuwait 8 Feb 2004 and spent two weeks training and getting briefs on the rules of engagement. A Co was split into three and we covered at least 7 sites north of Baghdad.

I was assigned to a treatment team that does sick call, holding and provides emergency coverage for part of the base. The finishing touches were being done to our hardened TMC as we set up tents to start providing medical care 2 days

after we arrived. In the beginning we were the only health care facility so we saw every injury, accident, gunshot wound, chest pain, shrapnel wound, walking wounded, civilian casualties and unfortunately US KIA. Now there are several BAS and a Medical Battalion so we cover only a portion of the base. We have been developing a mass casualty plan that is quite comprehensive and unfortunately we had to put it to use after several car bombs rocked one of our gates and we had 35 injured.

Initially we were dealing with patients who were having allergies commonly referred to as the "Iraqi Crud". The next wave dealt with patients who had pre-existing conditions who should not have deployed but proudly came over to help their unit out. However, they found out that the demands of a soldier in a war zone are far different than a weekend drill. Other patients had to deal with anxiety issues, combat stress and the reality that we were a long way from home. Soldiers reported with chest pain and had to be ruled out and we evaded to a CSH then referred to Germany for a stress test. Most ruled out and were returned to the unit several weeks later. However this decreased the fighting strength of their unit.

The second round of patients included febrile illnesses, diarrhea, IED injuries, VBIED injuries, mortar wounds, shrapnel wounds and Gun shot wounds. As Soldiers became accustomed to the climate and tired of the DFAC food they began to eat the local food and drink local beverages. This plus the chronic use of pot-o-potties lead to several cases of gastroenteritis. Some of which we kept in holding for IVF's or antibiotics for several days.

The attacks picked up shortly after we arrived. I have been extremely impressed with the combat survivability of the HUMVEE, especially if it is up-armored. It provides great protection from IEDs and unless the soldier receives a direct hit to the head or face their injuries are limited. IBA provides excellent protection and limits injuries to shrapnel wounds or amputations to the extremities. So far I have removed shrapnel from the scalp, eyes, face, neck, back, arms, legs and pubic area. Mortar wounds are a bit more complicated with traumatic amputations and multiple shrapnel wounds.

The third wave of trauma has been more orthopedic in nature. During periods of less frequent attacks soldiers perform more physical training. The terrain here is very unforgiving, unlevelled and dusty. Soldiers report to sick call with sprained ankles, lateral epicondylitis, wrist pain, or just name a joint pain. One soldier jumped off a five ton and dislocated and fractured his ankle, which we had to reduce. We also saw a soldier who dislocated his shoulder when he fell out of a 113 and landed on his arm during a mortar attack.

Labs and x-ray have been a bit of a challenge. We did not receive the ISTAT machines until 3 months in theater. The X-ray machine has been up and down.

However our staff has never lost focus and they have performed other duties as assigned without hesitation.

We have been blessed to have the most motivated and eager Soldiers that I have ever met. Some Soldiers work, as Paramedics, EMT's Fire Chief and others are students who do not work in the medical field outside of the military. Everyone must remember that they are a Soldier first as most everyone has pulled guard duty, provided security on convoys or performed jobs that are not their primary MOS. Medics have received training in ABC's, trauma management, suturing and wound care. There truly is no substitute for on the job training. Some medics have come a long way and I am encouraging some of them to advance their knowledge and consider PA school.

I would encourage everyone to train his or her medics to feel comfortable and skilled enough to perform the ABCDE survey, per ATLS protocol. Medical personnel should be able to secure an airway, needle decompress and apply Israeli dressings appropriately. I certainly wish I had more training time.

The Commander and his staff have been extremely supportive. They have let the medical personnel do their job. They have all provided assistance during mass casualties and even during sick call. Our supply budget does not seem to be a problem but the orders come in piece meal. All the headquarters staff have been extremely proficient in networking and obtaining supplies by alternate methods. In many ways this is an ideal medical practice. All I need to worry about is treating patients.

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Note from CPT Marin, Butler Range Complex Support Mission

The 1CD has a new rotational mission for its BCTs. The Butler Range Complex (BRC) Mission was from 15 May to 16 June 2004. As the "Standing By" Forward Support Battalion for 2BCT, 15th was tasked with several support elements (cooks, mechanics, & medics etc...) to provide "Outstanding Gambler Support" to 1CD personnel assigned to BRC, rotational 2BCT Force Protection Forces, and Contractors running the BRC, etc.

Some history on BRC, it was established September 2003 and run by 1AD until mid-May 2004 when 1CD took over. It is a 150 square kilometer, multi-range complex to include armored vehicles, artillery, aviation, small firearms, and explosive live fire. MPRI contractor personnel accommodate it with weapon familiarization, training, qualification, and convoy live fire exercises. Recently,

BRC is the location for the 1CD ICDC Basic Training Academy; first 13 day training cycle started the 30th of May 2004.

BRC was named after a courageous 1AD scout soldier, SGT Jacob L Butler. SGT Butler was Killed in Action (KIA) 23 April 2003 during the Division's attack to liberate Baghdad and the Iraqi people.

During our 30-day mission we saw a total of 262 patients. The patients were mostly Iraqi contractors, soldiers, some MPRI contractors, and a few severely sick and injured ICDC trainees. Seven different patients with various illnesses and injuries necessitating higher echelon point of care and evaluation were air evacuated. The medics did an excellent job stopping the bleeding and stabilizing a local father and son that had encountered a UXO. The BRC forward medical team consisted of SGT Brisson, SPC Ahern, SPC Kuykendall and CPT Marin.

The cooks did an outstanding job and were recognized several times by visiting VIP's (1CD CSM Hernandez & ADCM BG Jones). Kudos to SSG Herve and her cooking team, their food made the mission tolerable. As a rotational mission, 2BCT's next rotation will be mid-August to mid-September. The 1CD will hand it over to the incoming Division O/O mid-January 2005.

Notes from LT Schaaf

Since her arrival to Iraq in March 2004, 1LT Sherrill F. Schaaf PA-C, MPAS, the 4-5 Air Defense Artillery Task Force Medical Officer, has taken the lead in conducting Community Health Outreach Programs (CHOPS) in the rural villages southwest of Baghdad. These medical missions identify villages that are medically underserved in the rural countryside west of the Tigris River and to provide vital medical care to the Iraqis that are less fortunate than most. The 4-5 ADA Task Force mission is to conduct armored and motorized infantry patrols within the Renegade zone. The Soldiers interact with the local population on a daily basis and often find that there are a large number of people needing medical care. Once a village has been identified, it is targeted for a medical mission. The next step in providing care to these villages is to conduct a site survey by the Task Force Medical Officer and the maneuver battery that will provide security during the mission. The medical mission provides an excellent opportunity to interact and mingle with the local village population, gain additional knowledge of their customs and culture, and to gain the trust and cooperation of the villagers.

1LT Schaaf has participated in five separate CHOPS and has personally orchestrated and conducted three within the Renegade Task Force Area of Operations. All of the medicines distributed to the Iraqis are procured locally through a pharmacy in downtown Baghdad. In order to conduct successful CHOPS it is vital to have the assistance of other medical providers to assist with diagnosis and treatment of the large numbers of patients that arrive to the site of the medical mission. Other physician assistants and doctors that have joined 1LT

Schaaf in bringing desperately needed medical and dental care to the Iraqi farmers and their families are: an Iraqi doctor and dentist, several fellow Black Jack Brigade PA's, 1st Cavalry Division LSA PA's, Special Forces MD and PA, and SEAL team medical personnel.

The advantages of such a mission are far reaching. These unique experiences are ones that will stay with all who have participated for a lifetime. The rare medical diseases the medical providers see first hand leaves a lasting impression on their hearts and minds. At the most recent mission, 23 JUN 04, two siblings suffering from Macro-encephalitis is one example. Various other diseases such as Cerebral Palsy, Hydro-encephalitis, Lishmaniasis, and untold numbers of parasitic infections fill the day with amazing patient encounters not common in the USA. As the mission draws to a close, everyone in the village is asking when will we come again. The villagers are anxious for the medical providers to return and all of the providers are eager to go again. Even the Arabic linguist and interpreters volunteer to go on future Renegade medical missions. Currently, two additional CHOPS are in the planning stages for future medical missions.

4th Battalion, 5th Air Defense Artillery Regiment
2nd Brigade Combat Team, 1st Cavalry Division
Camp Black Jack, Iraq

Almost every day someone forwards a picture or news story of PAs in Iraq or other places around the globe. Whether you are active, Guard or reserve you are doing an incredible job. Again I thank you for all you do and the sacrifices you make every day. You are doing the hard work of the AMEDD!

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