



SAPA JOURNAL



The Society of Army Physician Assistants

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MORE ON ASSAULT LITTERS

Received from
Bud Calkin, VP/GM, Skedco Inc.

I read an article in the Nov/Dec issue of the Sapa Journal written by Donald Parsons on "Casualty Evacuation".

I am troubled by the inaccuracies in this article claiming that when a patient is dragged in a Sked that the Sked plastic material gets hot enough to burn a patient. I own Skedco and in 24 years of marketing my products there has not been even one report to come to me about such a thing. If it had happened I would be among the first to know. Let's be truthful about this Don.

He also stated that a patient must be insulated from the cold. That is true. He failed to mention that all litters require that, especially the Talon II because it was designed to allow fluids to pass through the fabric of the bed. Air, water and snow will penetrate to the patient. Convection current increases cooling of a patient from movement of air under the litter. All pole litters are affected because they have feet that hold the litter above the ground.

The Army has been using Skedco stretchers for over twenty years and I have yet to be informed that it is too unstable. Actually when used with the Oregon Spine Splint it is the same as along backboard. Just remember that no litter immobilizes by itself. I might add that patients cannot fall off of the Sked.

All Skedco litters are assault litters. Parsons seems to have conveniently left that out of his article. He could not say too much to discredit the Sked as it has been used to save lives where no other litter will perform.

I agree the Talon II is an excellent litter but it is still a pole litter and must be carried by 2 or more soldiers. The Sked can also be carried but functions extremely well when dragged by

one person, when taken through very small holes, when being used in the water, when used in high angle rope rescue and when being hoisted by helicopter. Pole litters do not fare nearly as well for these rescues.

The Marines may have selected the Talon II but the Army's mission requires two litter styles just as pointed out by Parsons. The Sked will evacuate patients from areas where other litters will not fit even with no patient on them and has done so many times. The Sked as pointed out by Parsons can also haul ammunition and equipment then be used to evacuate a patient. The only thing it cannot do that pole litters can is to be carried by the ends, however, one person can slide it just as easily as to carry a pole litter and most often easier.

The Sked fits in a UH-60 Black hawk crosswise and lengthwise. It is approved for hoisting and has been hoisted more times than count.

The Sked fits in a UH-60 Black hawk crosswise and lengthwise. It is approved for hoisting and has been hoisted more times than count.

The collapsible Sked System weighs less and fits in a smaller package than the Talon II. It can be used by one medic or combat lifesaver.

Don, I do not think the only platform should be a Talon II however I think both the Sked and pole litters are very necessary. Please say it like it is. Thank you.

Received from

Donald Parsons, MPAS, PA-C

The article on Casualty Evacuation from the Battlefield was designed to introduce assault litters to the audience and recommend their use for casualty evacuation. Many units already employ assault litters as part of their mission planning but not all do. If we are to practice effective care at the point of wounding and expect to move injured soldiers effectively.

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The SAPA Journal staff and SAPA Board of Directors encourages membership participation in this publication. Feel free to use this forum to present your views on any topic you desire. The publication of clinical articles on any subject is also solicited, however, to reduce our workload, we do request articles be presented typed, double-spaced format, and on 8 1/2 x 11 inch white bond paper or on CD or floppy", IBM compatible, in Microsoft Word format. The editor reserves the right of final acceptance of articles as well as the right to serialize articles which are too lengthy to be included in a single issue.

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This is not an official Army Publication.

It was never my intention to disparage the products made by SKEDCO. Quite the opposite, I heartily endorse all of the SKEDCO litters and teach them in classes on how to package a casualty for transport. Mr. Bud Calkins is a tremendous advocate for the U.S. Military and will go out of his way to come to your organization at his own expense to train on his products. I sincerely apologize to Mr. Calkins and his organization if I gave the impression that his products are anything less than excellent.

Received From

CW 4 (R) Rafael O. San Juan PA-C.

I received the latest SAPA Newsletter this week, and I am deeply appreciative of the article that was published on page 4 reference my civil service retirement. In the article there is a mistake (ours not yours) that I would like for you to rectify in your next newsletter. It states that I was the PA Consultant during the years of 1985-1988. I was the PA consultant to Lt. Gen Becker while in Europe. Once he became The Surgeon General and moved to Washington, during the years of 1985-1988, David Jenkins was the Surgeon General's consultant. I was the career manager during that time. Credit must be given where credit is due. I am sure this probably created some confusion with some of the older PA's that Dave and I worked with during those years. I look forward to reading about the correction on the next SAPA newsletter. Take care.

AAR IRAQ

Received By

CPT John Detro, PA-C

Objective : Classified

Mission: Capture insurgents

Location: Iraq

Composition of Force

Assault Force: 52 personnel in 6 vehicles traveling one hour to target

Assault medical assets:

1 medical vehicle: 1 medic, 1 Medical Officer

Second medic with PSG
Combat Search and Rescue (CSAR): 4 medics and 1 Ranger squad

Pre-positioned at Forward Operating Base (FOB) with Forward Surgical Team
3-5 min flight from target building

Primary mission: CSAR
Secondary mission: CASEVAC for

MASCAL situation. Casualty Evacuation (CASEVAC):

1 medic located at FOB

Air crew in aircraft as mission commences

Pre-Mission Planning:

Medical Assault Force:

Medical vehicle- contains oxygen, suction, AED, fracture kits, surgical kits, hemorrhage control equipment
Aid bags left on vehicle-too cumbersome to carry on assault

Medical personnel carry enough Class VIII on body armor to treat two seriously injured Rangers

PLT medic utilized a large fanny pack able to cover initial stabilization

MO and Senior medic used RFR fanny packs

- PA's fanny pack was packed mostly for hemorrhage control

- Senior Medic's packed mostly for airway

management.

Assault Force members carry Hemorrhage Control Kits which include Israeli Trauma Dressing, CAT tourniquet, ace wrap, and Pill pack (Tequin, Cox2 inhibitor, acetaminophen)

Squad EMT's carry Ranger First Responder Kits which include basic airway equipment, hemorrhage control and intravenous kits

CASEVAC Plan:

Primary: ground evacuation 7-10 minutes to FST for 1 seriously injured casualty

Secondary: CASEVAC by air to FST if one casualty

Tertiary: CASEVAC by air to CSH for MASCAL

Quaternary: CASEVAC and CSAR movement of multiple casualties to CSH

Mission:

Prior to target building, force conducts mission on first target utilizing explosive breach approximately 1 mile from secondary target. Force moves to second target by vehicle to 1000 meters from target and personnel dismount and begin ground movement toward building while hearing radio transmissions of enemy moving on target and adjoining roof tops. Lead element conducts explosive breach and immediately two Rangers shot with one sustaining left axillary artery injury (lying in courtyard but not identified until later in mission). Unit forces way into building and out of street. Senior Medic and MO closely behind assault force and reach platoon medic treating casualties as enemy engages with small arms fire and grenades from above. While treating casualties in hallway, all 3 medical personnel lightly

wounded by grenade fire and cover patients to prevent their exposure. Two insurgents flank assault force and killed within 5 feet of medical personnel who were oblivious to situation secondary to concentration on casualty care. Unit continues to sustain casualties and vehicles approach building for exfil. The unit could not afford to unroll Skedco litters and due to urgency of the situation medical officer opts to drag them despite probable lower extremity fractures. Two patients with bilateral lower extremity wounds with tourniquets applied are dragged to street after MO removes two dead insurgents from doorway. Several others are moved to the vehicle. The walking wounded continue to fight. Four litter patients placed in vehicle and platoon medic and MO begin treatment with remaining medic in building awaiting exfil. Platoon Sergeant runs to vehicle and asks MO to return to building. MO finds medic attempting application of Asherman chest seal to wounded Rangers left chest wall. Patient bleeding profusely but awake and displaying no shortness of breath. Medic and MO attempt to control hemorrhage with tourniquet. Medic finds wound is too high and applies Israeli trauma dressing. Patient moved to vehicle and is fifth casualty in four litter vehicle. Senior Medic begins reassessment of axillary artery patient by loosening dressing, applying HemCon dressing, and then redressing wound with control of hemorrhage. Below is a description of the medical care performed on the objective as related to the principles of Tactical Combat Casualty Care guidelines.

Care under Fire

- **Courtyard:** (still under fire) - body armor and MICH helmets left on casualties. Sensitive items secured by assault force
 - (Cax 1) Multiple shrapnel wounds BLE, abdominopelvic region and L arm. Bilateral tourniquets. Dragged to medical vehicle.
 - (Cax 2) Multiple shrapnel wounds to BLE. No airway compromise, moderate venous bleeding, A&O X 3. Exposed wounds, Kerlix and Israeli to heaviest bleeding.
 - (Cax 3) Multiple shrapnel wounds to BLE and GSW to L tibia and L axillary artery with arterial bleeding. A&O X 3. Exposed wounds, wound too high for tourniquet application, ACS then Israeli on top (bleeding temporarily controlled).
 - (Cax 4) Multiple shrapnel wounds to BLE, A&O X 3. 11B RFR treatment then evacuated onto the Medical vehicle.
 - (Cax 5) Multiple shrapnel wounds to BLE.
 - (Cax 6) Multiple shrapnel wounds to L side of body. Able to continue fighting. No treatment until casualty

evacuation (move with assault force).

- (Cax 7) Multiple shrapnel wounds to R leg (walking wounded). No treatment until casualty evacuation (move with assault force).

Patients moved to Helicopter Landing Zone with four most severe being loaded first. Confusion between ground commander and air commander's leads to confusion as CASEVAC medic believes he is only platform for evacuation while CSAR prepares for possible insertion of Ranger Squad. CASEVAC Medic makes right decision based on information and moves patients to FST with Ranger medic accompanying him. CSAR aircraft lands and MO joins team and directs flight to CSH. MO arrives at CSH to find first patients had been inadvertently evacuated to FST. Patients were reassessed at FST but flown to CSH for surgical intervention (received reassessment, redressing and blood products for axillary artery patient) with total time from evacuation to arrival at CSH over 1 hour.

Tactical Field Care

Medical vehicle

- Cax 1) One 400mcg Fentanyl lollipop and 10mg Morphine I.M. (little to no effect on pain). Kerlix applied to heaviest bleeding. Blanket to stabilize pelvis (possible pelvic fx-shrapnel).
- (Cax 2) Removed boots and loosened all constrictive clothing due to impending compartment syndrome, loosely wrapped Kerlix around legs. One 400mcg Fentanyl lollipop and 10mg Morphine I.M. (little to no effect on pain).
- (Cax 3) Heavy arterial bleeding started to seep through ACS, no difficulty breathing. Removed ACS and applied HemCon, Kerlix, Israeli Trauma dressing, and then reinforced with an Ace wrap (achieved hemostasis). 20mg Morphine I.M. (little to no effect). Applied Kerlix to other minor wounds (hemostasis achieved).
- (Cax 4) Multiple Shrapnel wounds to BLE with impending compartment syndrome and minimal external bleeding. Loosely wrapped wounds with Kerlix (achieved hemostasis). One 400mcg Fentanyl lollipop, 20mg Morphine I.M. (little to no effect on pain management).
- (Cax 5) Multiple shrapnel wounds to BLE, loosened Kerlix wrap, one 400mcg Fentanyl lollipop (patient complained very little about pain).

CASEVAC Care:

- FST: 3.5 minutes– most seriously injured casualties evacuated to FST
 - (Cax 1) reassessed wounds, IV 18g SL R arm.
 - (Cax 2) reassessed wounds, wrapped with Kerlex, monitored vitals, IV SL
 - (Cax 3) Reassessed wounds, 10 mg MS, IV 18g SL R arm. Pain control established.
 - (Cax 4) Reassessed and wrapped legs with Kerlex.
- CSH: 15 minutes– casualties quickly evacuated to CSH
 - Cax 5) Reassessed and dressed wounds, IV 18g SL R arm.
 - (Cax 6, Cax 7) reassessed wounds wrapped with Kerlex. Monitored vitals. IV SL Cax 6.

End State: 30 minute firefight within building leads to 21 Casualties from small arms and grenade fire.

228th CSH conducts surgery on eight Rangers: One axillary artery repair, five fasciotomies (due to secondary blast effects of grenades), three arthrotomies, one exploratory laparotomy, and numerous wound irrigation/debridements.

The most common non-surgical injury is tympanic membrane rupture from primary blast effect of overpressure.

Casualty 1 (GSW): Left axillary artery repair. Evac'd to Landstuhl.

Casualty 2 (Grenade) : Exploratory laparotomy after free air seen on CT abdomen but no bowel perforations or vascular injuries, right forearm fasciotomy secondary to compartment syndrome, right knee arthrotomy secondary to shrapnel. Evac'd to Landstuhl

Casualty 3 (Grenade): Bilateral lower extremity compartment syndromes released via fasciotomy. Evac'd to Landstuhl

Casualty 4 (Grenade): Right lower extremity compartment syndrome released via fasciotomy. Evac'd to Landstuhl

Casualty 5 (Grenade): Left open tibia fracture without evidence of compartment syndrome, surgical irrigation and debridement followed by splinting. Evac'd to Landstuhl

Casualty 6 (Grenade): Right wrist shrapnel wound with small radial styloid fracture. Foreign body removal performed without need for surgical intervention of fracture resulting in splinting. RTD after profiling.

Casualty 7 (Grenade): Inability to ambulate due to right leg weakness. Multiple shrapnel wounds but no compartment syndrome. Evac'd to Landstuhl where EMG/NCS reveal sciatic nerve

Casualty 8 (Grenade): Right knee foreign body removal with RTD after profiling.

Remainder of force evaluated and numerous shrapnel wounds and tympanic membrane ruptures treated conservatively.

After Action Review included pre-mission planning, tactical combat casualty care guidelines, CASEVAC movement of casualties (FST versus CSH), and coordination with friendly forces (FST).

Sustain

- **Issue:** Utilization of Medical Evacuation Vehicle.
- **Discussion:** Multiple missions were previously conducted without MEV even though primary means of evacuation via ground. It would not have been possible to treat casualty's enroute to CASEVAC if not utilized.
- **Recommendation:** MEV should be utilized on all Ground Assault Force Missions (GAF).

- **Issue:** Increased medical capability.
- **Discussion:** On the majority of raids some medical personnel were left in the MEV. If the threat is high and the Vehicle Drop Off (VDO) is a distance from the objective medical personnel are not in a position to move to the casualties to provide care.
- **Recommendation:** During high threat forced entry missions all medical personnel move with the unit to the objective.

- **Issue:** Review of Tactical Combat Casualty Care (TCCC) Guidelines.
- **Discussion:** Patients treated according to unit protocols and sustained injuries compatible with TCCC Training examples (i.e. no airway adjuncts needed)
- **Recommendation:** Continue to train to TCCC guidelines and revise as lessons are learned.

- **Issue:** Training on compartment syndrome caused by blunt/penetrating trauma to extremities.
- **Discussion:** Lecture given on compartment syndrome prior to mission. Communication with Landstuhl surgeons revealed over 60 cases of missed compartment syndromes leading to permanent disability or amputation.
- **Recommendation:** Continue to include compartment syndrome in medical training scenarios and stress vigilance of wound reassessment.

- **Issue:** Ranger First Responder training and treatment
- **Discussion:** Continue to train infantryman on RFR tasks.
- **Recommendation:** Continue to emphasize bandaging and hemorrhage control rather than I.V.'s

Improve

- **Issue:** Pain control of severely injured patients.
- **Discussion:** The Fentanyl lollipop (400mcg) has been effective for severe sprains and blunt trauma fractures but has not provided adequate relief for severe injuries such as gunshot wounds/compartment syndromes. The time to action is delayed and most patients required I.V. Morphine to control their pain.
- **Recommendation:** Maintain Fentanyl as an option for mild/moderate pain but have a low threshold for utilization of Morphine. Consider 800mcg Fentanyl lozenges.
- **Issue:** coordination with FST prior to mission.
- **Discussion:** Upon patient arrival repacked wounds and provided blood. However, no surgical attempt at hemostasis on axillary artery injury.
- **Recommendation:** Due to limited increase in flight time coupled with improved capability recommend over fly to CSH.
- **Issue:** Skedco litter in urban environment.
- **Discussion:** The Skedco litter has been outstanding in many environments (desert, mountains, and streets) but not MOUT. The Skedco requires unfolding, flattening, and strapping the patient into the litter. This is not an option in the "care under fire" phase of an urban raid. Patients were drug into the street with body armor, MICH, and other equipment.
- **Recommendation:** Explore simple rigid litters that are easy to open/carry and require no straps. The patient can be quickly carried to a safe area (MEV, etc) and transloaded to a more stable litter when time and tactics permit. Unit will utilize RAGE litter on next training mission to determine efficacy in MOUT environment.

2nd Annual Spring Professional Issues Symposium

April 7 & 8th Radisson Hotel & Plaza, Kalamazoo, MI
www.michiganpa.org or email mapa@michiganpa.org

31st MAPA Annual CME Conference

October 12-15

Grand Travers Resort, Traverse City, MI
www.michiganpa.org or email mapa@michiganpa.org

Bond of Wounded Warriors Crosses Generations

Received by
Sean Meadows, CPT, MC

As an Army emergency medicine resident, I am reminded every day that we are a country at war. From the staff physicians in constant rotations, to Iraq and Afghanistan, to the wounded warriors who fill our wards and rehabilitation centers at Brooke Army Medical Center, the thought of war and its consequence permeates my experience as an Army physician. I see the news reports of wounded in Iraq and Afghanistan, and hours later they come through the doors, flown in for intensive and sometimes long-term care. An intangible benefit this Army hospital offers to men and women wounded on today's battlefields is contact with other veterans. I have seen soldiers from World War II, Korea, Vietnam, the first Desert Storm, and assorted other conflicts talking to and encouraging these young warriors. One of the most poignant memories of my residency was when I saw a young burned soldier with a right leg amputation and a badly broken left leg being confronted by a boisterous man in his 50s saying, "Hey, did you lose your leg in Iraq?" The soldier mumbled "yes," and the man said, "Hey, look, I lost my arm in Vietnam. " He produced his stump, and they spent the next 30 minutes talking together in a way I could never connect with either one.

I am ever aware of the consequences of war and how life changes in an instant by my daily encounters with these patients. I have never heard a combat wounded patient say they wish they hadn't gone to war. Even the most horribly burned and wounded that I have met want to rejoin their buddies and go back. Their strength sustains me as I tend to them in the intensive care unit and on the wards.

My lack of sleep and long schedule gets put into perspective as I see why I train. It's hard to grumble when you see a man with extensive injuries battle pain and infection and endure multiple surgeries without complaint.

Many people are unaware that we are taking care of wounded soldiers here at Brooke Army Medical Center. More than 2,400 wounded, burned and injured servicemen and women have been treated here since the global war on terrorism started. For some of them the battle is far from over; they face life-threatening infections from bacteria indigenous to Iraq as well as the burns and trauma they have suffered.

Though we weren't there when they were wounded, we join them on their new battleground committed to restoring them. We do anything we can for them. As we all are reminded daily, they fought for us, now we fight for them.

Tactical Combat Medical Care (TCMC)

Course Description:

This course is designed to provide the Physician Assistant, Physician and senior medical NCO a practical working knowledge of how to deal with the injured patient in a combat environment. The course information will be based on known trauma resuscitation methods, lessons learned from past and current combat environments and from newly developed technology. Training will consist of didactic lecture and hands-on practical training. The topics include the initial assessment of the patient, specific trauma injuries, environmental injuries and emergency surgical procedures as it applies to the combat casualty. The course is conducted a total of 7 times a year. There will be 3 iterations taught during the OBC PA Track and an additional 4 stand-up iterations. The course is aimed at the care provided at levels I/II. The course will offer new ideas on class VIII options and management during the post-resuscitation period prior to evacuation. Upon successful completion of the program, the Physician Assistant student will be authorized to claim a maximum of 40 hours of Cat I CME.

Course Goals:

The evaluation, resuscitation and management of the wounded soldier presents a unique challenge to the medical provider. The modern battlefield and advancements in technology have changed our way of thinking in the approach to combat casualty management. Through "lessons learned" we have found that traditional ATLS/BTLS formats are not applicable to the combat casualty. This course will provide information on how to apply known concepts in trauma to the combat casualty in the combat environment. This course will emphasize the following concepts:

1. Initial Assessment of the combat casualty
2. Initial resuscitation and stabilization
3. Management of specific combat injuries
4. Emergency surgical procedures
5. Post resuscitation management

Course Format:

Given the depth of the topics involved in trauma management, this course will focus on the problems and differences in doing trauma management on the modern battlefield.

1. The course will be offered to medical Physician Assistants with the potential for Physician and senior NCO participation. The emphasis will be placed on Level I and Level II medical care.
2. Each topic will be presented in a Powerpoint format conducted at the Academy of Health Sciences. Each instructor has been identified as having experience in the combat environment.
3. At the end of the course, the students will get a chance

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to practice their procedural skills during a live tissue lab. With support of the Veterinary services the students will have the opportunity to practice emergency surgical skills on a live animal model. This event will also be conducted at the veterinary lab.

2. The final event will be a series of comprehensive hands-on patient scenarios aimed at tying in all of the information that has been presented throughout the course. We will utilize the Simulation lab created at the 91W schoolhouse. After each scenario there will be small group discussion utilizing the AAR format.

Next Course: 27-31 March 2006

POC: CPT James Rice 210-221-6658 or 7330

CPT Patrick Williams, PA-C Awarded Silver Star!



LTG Vines, MNCI Commanding General presenting CPT Patrick Williams the Silver Star in Mosul, 30 Dec 05

After spending just twenty-four hours on the ground prior to the combat reconnaissance patrol, CPT Patrick Williams volunteered to accompany soldiers from HHC 1-5 IN. With very little time to acclimate, CPT Patrick Williams immediately chose to take part in the combat patrol and provide additional medical support. This decision would directly result in saving SSG Nicholas Malich's life. On August 31, 2005, the reconnaissance platoon from 1st Battalion, 5th Infantry Regiment, conducted an electronic reconnaissance patrol in the Intesar neighborhood in Mosul. During the patrol, the platoon leader, LT Scott Brandt, received intelligence that a High Value Target (HVT) was in the battalion area of operations. Upon locating the possible target house, the platoon, as well as CPT Patrick Williams dismounted to cordon off the objective area. As the platoon moved toward the entrance of the building, two anti-Iraqi forces (AIF) tossed grenades down the stairway at the squad entering the house. Simultaneously, SSG Malich's squad was hit by automatic PKC machine gunfire from an elevated position causing life-threatening wounds to SSG Malich's pectoral muscle and shoulder. Upon hearing the calls for help, CPT Williams moved

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First Class

ADDRESS CORRECTION REQUESTED

to the entrance of the courtyard and immediately administered first aid. While treating SSG Malich, CPT Williams and the rescue team were again engaged by the enemy with light machine gun weapons that impacted within a few feet of the rescue. CPT Williams immediately covered SSG Malich's body to shield him from the incoming fire while maintaining pressure on his wound. The platoon medic was shot in the right arm during this engagement, leaving CPT Williams as the only medical personnel on the objective. During his initial treatment of SSG Malich, CPT Williams realized that he could not get to the artery in order to stop the bleeding. While the rescue team maintained suppressive fire, CPT Williams made a three inch incision above the wound to locate the artery. CPT Williams' split second decision to make a larger incision was successful enough to allow four fingers inside which in turn stopped the bleeding. CPT Patrick Williams held the artery closed during the entire evacuation process which lasted 30 minutes. If it were not for CPT Patrick Williams' quick actions, SSG Malich would have bled to death in a short amount of time due to the large volume of blood he had lost prior to being treated. During the evacuation of one litter urgent patient and one walking wounded, CPT Williams provided simultaneous medical care in the back of a Stryker on the move. While continuing to maintain pressure on SSG Malich's artery, CPT Williams barked out instructions to the team concerning the care of SPC Alavarez who was wounded in the arm. CPT Patrick Williams maintained pressure on the wound throughout the entire transfer from the Stryker to the operating table. The 228th CSH on call surgeon stated that if it was not for his quick thinking and innovative techniques, there was no way SSG Malich would have survived much less been able to keep his arm. CPT Williams' courage under fire and quick

thinking directly contributed to saving the life of SSG Nicholas Malich. His actions truly represent the highest degree of valor and reflect great credit upon himself, the 4th Battalion 23rd Infantry Regiment, and the United States Army.

TAPS FOR KEN SHEERAN

Born in providence Rhode Island on July 27, 1945. He was the first child born to Lloyd and Doris Sheeran. Ken's mother was a nurse who passed away when Ken was only 14 years old. This had a very profound impact on Kenneth's life. He chose the medical field when he joined the Army in 1964 and dedicated his entire military career helping others and serving the U.S. Army. In 1964 he met Mary Yeager, fell in love and had married her that year. They had two children by 1968, "Eric Allan," and "Brian Kieth." In 1970 Ken was sent to Vietnam with the 9th Infantry Division at Da Nang and Dong Ha as a medic. Thank God he made it home in 1971. After returning to the States, he was accepted to the US Army Physician Assistant Program at Fort Sam Houston. He continued his career as a PA until his retirement as CW3 from the U.S. Army on New Years Eve of 1984 at Fort Leonardwood, Missouri. After leaving the Army, he worked as a Physicians Assistant at William Beaumont Army Medical Center, continuing to care for soldiers and their families. After 18 years in Civil Service, Ken medically retired in from William Beaumont Army Medical Center in 2004. In all his years of service, Ken saved lives, helped the sick, and helped calm the nerves of families who were worried about their loved ones. He was truly dedicated to helping any one he could. In the late spring of 2005, Ken became ill and fought his illness without knowing what it was or what was happening to him. His loving wife, Mary, never left his side until his death on November 16, 2005 in Las Palmas Medical Center. He is and always will be deeply missed by his family who shared him with the U.S. Army and mourn him with the U.S. Army. He gave his service with pride, dedication and honor. He gave his all.