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# SAPA JOURNAL

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A Civilian Organization Representing Army PAs

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## POINTS OF INTEREST:

- Day to Day Life with an FST
- Predeployment Medicine
- Physician Associate
- RAW Program

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## Day to Day Life Deployed with an FST

**By: CRAIG PAIGE MPAS, PA-C  
745TH FST COMMANDER**

Day to day life in an FST is not unlike other medical units I've deployed with throughout my 22 years on active duty; we've all heard it described as a life of Feast and Famine. From a command perspective, the challenge becomes maximizing the down time in preparation for the chaos that is waiting just around the corner.

An FST by MTOE is a small 20 person detachment consisting of 3 general surgeons, 1 orthopedic surgeon, 2 certified registered nurse anesthetists (CRNA), 1 operating room nurse, 1 emergency room nurse, 1 critical care Intensive care nurse, 3 operating room technicians, 3 licensed practical nurses (68WM6), and 3 medics. In my case, and as was the case for LTC John Balser, the first PA to command an FST, we have 21 personnel. In both situations, the addition of an orthopedic trained Physician Assistant as commander was an augmentation to the team instead of a replacement for one of the surgeons who are typically placed in command of the team.

The 745th FST deployed in August of 2010 to RC East Afghanistan in support of 1st Brigade, 101st Airborne Division (Air Assault). We are very lucky to be co-located with C-Co. 426 BSB and equally fortunate to operate as a fully intact FST. Several other FSTs in our area of operations are split between two different locations which anyone can imagine comes with its own unique set of issues and challenges.

To date, 5 months into the deployment, we have performed 187 trauma resuscitations. Presentations mostly arise from IED blast injuries; however we have also received a fair share of gunshot wounds, penetrating shrapnel injuries, amputations, major burns, motor vehicle accidents, traumatic falls and other combat related blunt trauma.

Our daily battle rhythm consists of morning PT and a regular team accountability meeting. Meetings are immediately followed by a 15-30 minute training presentation centered on equipment and procedures we use during trauma resuscitations. Soldiers from all sections (ATLS, OR, an ICU) give short classes on the set up and use of all FST equipment so that every member can confidently function in any section. Daily function checks of all FST equipment and checks to ensure reliable stock of commonly used supplies in every section are mandatory immediately following the mornings training. We never know when the call from Bastogne medical operations will come announcing that combat casualties are in route.

## Day to Day Life with an FST (cont.)

As the team prepares for the casualties arrival, the entire FST is engulfed in a cloud of serious professionalism as every individual anticipates their role and wonders what atrocities will enter the ATLS door. Intravenous fluid bags are spiked, warming blankets are placed strategically at each trauma bay, and team leaders quietly brief their team members regarding the often limited patient information gained from Med Ops. Everyone knows why we are here and how important each individual is to the success of our mission.

Patients are brought into the ATLS section according to their triage category, the most urgent going to trauma bay #1 which is located just 10 feet from the OR and closest to the lab and x-ray viewing monitors. Unlike what you might expect or see on TV, there is little to no talking, FST members immediately begin performing their specific member tasks... (airway, breathing, circulation, deformities, and exposure). After a functional airway and good circulation has been confirmed and communicated to the trauma team leader, the EVAC medic is asked for a report of treatment interventions rendered in route. All team members listen intently as they continue obtaining vital signs, establishing I.V access, draw trauma labs, and remove all clothing from the casualty. Once satisfied with the primary survey of the patient, a secondary survey is conducted. This includes rolling the casualty on one side to examine the back for injury, evaluation of all wounds and deformities, ultrasonic FAST exam and interpretation of the labs to gain an understanding of the casualty's metabolic condition. More often than not, we encounter incidence of large amounts of blood loss which make necessary the activation of our walking blood bank. It never ceases to amaze me how many soldiers and civilians show up literally minutes after the call for type specific blood is announced to help a comrade in need. One night in particular saw 56 units of whole blood drawn from donors and infused into two soldiers, both of whom are alive and recovering in the U.S. from unbelievably major IED blast injuries.

I've been asked on more than one occasion by non-medical people that have witnessed several of our resuscitations, "how do you guys seem unaffected by the horrific sight of large penetrating wounds and traumatically amputated limbs"? My response is always the same, "we train every day on how to concentrate on doing the basics; airway, breathing and stop the bleeding.

I consider myself extremely blessed as a Physician Assistant to be entrusted with command of a deployed Forward Surgical Team. The rewards of working in such a vitally critical piece of the military medical system extend well beyond any medal that can be pinned on a uniform. I encourage all my military PA colleagues to aggressively seek opportunities like this; I guarantee it will serve as the highlight of your career. **Armed Savior- Rightfully Proud!**

*"Everyone  
Knows why we  
are here and  
how important  
each individual  
is to the success  
of our mission"*

*MAJ Craig Paige  
CDR 745th FST*

## Day to Day Life with an FST (cont.)

**745th FST/Charlie MED**



*More often than not, we encounter incidence of large amounts of blood loss which make necessary the activation of our walking blood bank.”*

**MAJ Craig Paige  
CDR 745th FST**



**Major Craig Paige  
FST Commander**

## Physician Associate: A Change Whose Time Has Come

The following article was provided by **Dave Mittman, former AAPA president.**

### Final Statement of 100 PA Leaders

We, the undersigned physician assistant leaders assert that the time to change the name of our profession has arrived. While we can debate much about a name change, we have all agreed to the below statements and thoughts. We also fully agree that the name change advocated below will advance the profession. We call on the leaders of the profession and all PAs to announce and start to implement this change as soon as possible. At a minimum poll the entire profession. We are leaders who believe it is increasingly unwise to wait longer to make this long-needed change. Collectively, the below-signed PAs have given much of their lives to the profession and are dedicated to its advancement.

### Why We Need a Change

Our profession's original name was physician associate. Physicians demanded that "associate" be changed on the grounds that it did not properly describe the desired scope of PA practice. Forty years later we have outgrown the "assistant" title. It no longer accurately represents the profession. It is inaccurate and confuses consumers. The title is misleading and carries negative connotations which we can and should avoid. As we move into a new model of healthcare delivery it is of the utmost importance that our profession's name accurately describes our role.

### Why a Change Is Justified

-- The PA role is truly one of partnership; of association and collegiality. We work as associates and have for many years. Our profession's birth-name in 1965 was physician associate.

-- "Physician's assistant" is a generic term. It can mean anything: a person in the office that bills patients, records assistant, and the person that sets up and cleans the exam room, all the way to a certified, licensed PA. The profession must move from this generic name to one that aptly and more accurately describes our function.

-- In our society, "assistant" denotes a technical job, not a profession.

-- PAs are held to the same legal and medical standards as physicians.

-- The title is confusing and misleading to our patients and the public in general. Since the name practically guarantees that "physician assistants" will be confused with "medical assistants", patients are at risk of thinking they are receiving substandard care or expect that after the "assistant" a physician will also be seeing them. Most times this does not happen, nor does the physician or the PA expect it to happen. It is time to have the name mirror the reality that exists.

*"Our profession's original name was physician associate. Physicians demanded that "associate" be changed on the grounds that it did not properly describe the desired scope of PA practice. Forty years later we have outgrown the "assistant" title."*

*"The profession, ideally through the AAPA Board or HOD, should immediately adopt a policy that states that "Hereafter the profession will work to be retitled "Physician Associate," as it more accurately reflects the profession in the 21st century".*

## Physician Associate: A Change Whose Time Has Come

- The internationalization of PAs is important to the profession. Having to explain that the common meaning of the name "assistant" under-represents our true practice and is a barrier to understanding within international forums.
  - The above problems also may keep prospective applicants and others away from becoming PAs as they would not want to go through extensive schooling only to become someone's assistant.
  - Almost all professions at the level of training of a PA (pharmacy, PT, OT, NP) are or soon will be at the doctorate level. Our education and practice is professional, as should be our title.
  - "Assistant" obscures the PA's true role in the practice. Physicians who might otherwise consider a PA do not hire one as they feel they need someone more than just another "assistant".
  - All professions should be able to name their profession. "Physician Assistant" both demeans and misrepresents our profession. It is time to claim the name that is both appropriate and our birthright and discard the one that was forced upon us.
- The Process
- The profession, ideally through the AAPA Board or HOD, should immediately adopt a policy that states that "Hereafter the profession will work to be retitled "Physician Associate," as it more accurately reflects the profession in the 21st century".
  - If the Board or House is reluctant to do this on their own, then the entire profession should be polled using the AAPA's full database.
  - This renaming can be done over a number of years, with the ability reserved to use either title in the interim if necessary, depending on state legislation, etc.
  - The PA profession should advise organized medicine that this change is not an effort for independent practice but is a move to more accurately describe the scope and status of the profession and place it at a level where it belongs. It should also be explained that the name physician associate had been chosen for us by organized medicine to represent the PA profession 45 years ago. PAs should stress that after 45 years of delivering quality medical care across the entire spectrum of practice, we are choosing a more appropriate name and that we would expect nothing less than the full support of organized medicine, which will also benefit from the change.
  - PA programs should include the name physician associate whenever possible--along with the title physician assistant if need be.

## Physician Associate: A Change Whose Time Has Come

- "Physician Associate" allows us continued use of the initials "PA", which are well-known to the public.
  - "Associate" does not imply that PAs are equal to physicians. Associate professors are not full professors. Associate deans are not full deans. There are precedents for this.
  - The profession should consider funding State-level efforts to effect this change.
  - The argument that a change will open laws at the State level is a hollow one. This action can be introduced as a "cosmetic" name change amendment which will have no impact on PA practice law. If opposed, the profession can educate the legislature as to the source of this opposition, as we are asking for no increased privileges, and the current title is confusing consumers and others
  - This name change should be done BEFORE the profession embarks upon any large public relations campaign. We can effectively brand the profession through the use of the new name, avoiding any confusion of our status when compared with medical, podiatry, chiropractic and other assistants.
- Therefore, we the undersigned PAs declare that because of the above reasons and more, the PA profession should adopt the name "Physician Associate" and begin an educational campaign to other medical professionals and the public regarding Physician Associates.
1. Victor H. Germino, PA. PA Class #1, 1965-67 Duke University Medical Center PA . Victor is one of the founders of the PA profession.
  2. Robert M. Blumm, MA, PA-C, DFAAPA, Immediate past president APSPA, Past president AASPA, Immediate past president ACC, Past president NYSSPA, Past AAPA Liaison To ACS, ACC Liaison to ACS, Past Chair Surgical Congress AAPA, Editorial Board Advance for PAs, Clinician I, Advanced Practice Jobs, past editorial board member Physician Assistant, Clinician News, Author, National Conference Speaker, Consultant, Paragon Award Winner Physician /PA Team, John Kirklin M.D. Award for Excellence in Surgery.
  3. Robin Morgenstern, PA Past AAPA Secretary, Past President Illinois Academy of PAs, past Director of the PA Program of Cook County Hospital, Chicago, Past Midwest Advertising manager Clinician Reviews Journal.

*“The argument that a change will open laws at the State level is a hollow one. This action can be introduced as a “cosmetic” name change amendment which will have no impact on PA practice law.”*

## Physician Associate: A Change Whose Time Has Come

4. Maryann Ramos, MPH, PA-C, Founding President NJSSPA, Secretary of the AAPA House of Delegates, Delegate or Alternate for many years; Current Member, Nominating Committee; Current Legislative Chair for Physician Assistants for Latino Health - Puerto Rico; Past President American Academy of Physician Assistants in Occupational Medicine; Established Liaison between occupational physicians and PAs and Affiliate PA Membership in ACOEM; Awarded the Meritorious Civilian Performance Medal, US Army Medical Corps, 2008; Past Federal Civilian PA of the Year 2002(AAPA Veteran's Caucus); Past PA of the Year (AAPA President's Award 1980).

5. Blaine Carmichael, MPAS, PA-C, DFAAPA, Co-Founder Association, Past president, Vice President and current Delegate at Large of Family Practice Physician Assistants, Founder Bexar County PA Society, Founder, Que Paso - What's Happening PAs of San Antonio, Moderator of PRIMARY PA forum, Board Member, American College of Clinicians, Founding member of PA History, Texas PA of the year, 1990, has published widely and speaks at many national, state and local PA conferences.

6. Dave Mittman, PA. Past AAPA Director, Past President NY State Society of PAs, Co-Founder and creator Clinician Reviews Journal and Clinician. Co-Founder ACC. First PA to serve in the USAF Reserves. Lifetime PA Achievement Award/President's Award NJSSPA and NYSSPA. Co-Author of first international article regarding PA practice in America published in the BMJ. AAPA National Public Education Award Winner-1983.

7. Stephen Henry, PA-C, RNP, Co-Founder California Academy of PAs. Two times President of CAPA. Founding member of Veterans Caucus, Founding Member Occupational Medicine Caucus AAPA. Founding Member ACC. Years in HOD, Numerous committee Chairmanships.

8. Harvey Fine, PA-C Founding President, California Academy of Physician Assistants.

9. David M. Jones, PA-C, MPAS, DFAAPA, Member, Past Governmental Affairs Council, AAPA Legislative Co-Chair for at least 10 years, Oregon Society of PAs (Chair for the 2009 session), Past President of OSPA (twice), AAPA Co-Rural PA of the year 1988; second term as a member of the PA Committee, Oregon Medical Board.

10. Roy Cary, PA-C, DFAAPA Co-founder and past president of The American Academy of Physician Assistants in Legal Medicine. Co-founder in Cary & Associates, LLC and holds a position as Senior Partner. Mr. Cary is also a member of the Physician Assistant Advisory Committee of the Nevada State Board of Medical Examiners. Retired Air Force Major.



## Physician Associate: A Change Whose Time Has Come

11. James R Piotrowski, PA-C, MS, DFAAPA, Co-founder Association of Neurosurgical Physician Assistants, Past president of ANSPA, Past Vice President and board member of FAPA, Co-founder of the FAPA-PAC, Past member Florida BOM PA Committee, Past Trustee of the AAPA PAC and Chairman of the AAPA-PAC, Past PA member of the council of AANS and CNS, Past editor of the ANSPA's Journal.

12. Lisa D' Andrea Lenell, PA-C, MPAS. Internal Medicine PA, Adjunct Faculty Midwestern University, National Radio Host Reached XMI60.

13. Michael Halasy, MS, PA-C Health Policy Analyst/Researcher. Author of well-known PA Blog.

14. Gary Falcetano, PA-C, Bariatric Medicine, Stockton NJ, Managing Director – Collaborative Clinical Communications, LLC. Captain (Ret.) US Army Reserve, Past Group Publisher Clinician Reviews / Emergency Medicine / Urgent Care, journals.

15. Charles O'Leary, PA-C, Hominy Family Health Center [FQHC], 35-year practice same site; LTC [Retired] US Army/OKARNG [2 tours Afghanistan, awarded BSM/CMB]; past-OAPA Vice-President, Past OAPA Newsletter Editor, 1992 Oklahoma Rural PA of Year, OU-Tulsa Medical College PA Preceptor, Past Hominy School Board President, Past Commander American Legion Post 142.

16. Gerry Keenan PA-C, MMS, Emergency Medicine, AAPA Professional Practices Council, Charter member SEMPA. Charter member AFPPA. Charter member ACC. Bar Harbor, Maine

17. Martin Morales, PA MHA. Director Physician Assistant Services, Long Island Jewish Medical Center / North Shore LIJ Health System.

18. Stephen E. Lyons MS, PA-C, W .Cheyenne Clinic Coordinator, Take Care

19. Robert Nelson, PA-C. Executive Director, Island Eye Surgicenter, LI, NY. Administrator of various surgi-centers in NY metropolitan area, Author, Speaker, Director at Large-Outpatient Ophthalmic Surgery Society, Member Corporate Development Planning Committee OOSS, Consultant, Surgical PA 30 years.

20. Eric Holden, PA-C, MPA, EMT-P, DFAAPA. 23 years of practice in emergency medicine. Member of state, federal, and international disaster medical teams. Medical provider at level 1 and 2 trauma ctrs, HMO's, community E.D.'s, rural/under-served E.D.'s, and solo provider at high acuity inner city facility. Author of multiple articles in peer reviewed medical journals.

21. Rebecca Rosenberger, MMSc, PA-C, Current President AAPA- Allergy Asthma and Immunology.



## Physician Associate: A Change Whose Time Has Come

22. Michael Jones, MPAS-C, Chair PA Section American Headache Society, Director Cascade Neurologic-Headache Clinic.
23. Pamela Burwell, MS, PA-C. Distinguished Fellow, AAPA. Founder and Director, Peace Work Medical Projects. AAPA Humanitarian of the Year. Arizona PA of the Year.
24. Eleanor H. Abel, RPAC, MS, CRC Upstate Medical University, Syracuse. Director At Large, NYSSPA. Liaison and membership chair for NYRCA. Medical provider with 22 years of experience in Hematology/Oncology and previously employed in Surgery and also Physical Medicine and Rehabilitation. Specialize in pain management, advocacy for people with disabilities, past coordinator and current assistant coordinator for the NYSSPA Public Education Committee.
25. Ronald H. Grubman, PA-C Founder, Conmed Inc., 1984. President and CEO for 23 years. Conmed acquired and currently a public company on the NYSE.
26. Ken Harbert, Ph.D., CHES, PA-C, DFAAPA Dean, School of Physician Assistant Studies. South College, Knoxville, TN.
27. Eric Schuman, MPAS, PA-C. Adult & Pediatric Neurology Kaiser Permanente Portland, Oregon. Adjunct Assistant Professor, Oregon Health & Science University Physician Assistant Program.
28. Charles A. Moxin, MPAS, PA-C, DFAAPA, Past President Association of Family Practice Physician Assistants, Past AAPA HOD delegate for Family Practice, Past Editorial Board member for Arthritis Practitioner, Author, National Conference Speaker, Pharmaceutical Advisory Board member.
29. Kenneth E. Korber, PA PhD (c): Director of Strategic Development - CE Outcomes LLC, Curriculum Architect - First PA Postgraduate Fellowship in Cardiovascular Care, Clinical Associate University of Illinois College of Medicine, Past Member Board of Directors: Association of PAs in Cardiology, Member - Association of Postgraduate PA Programs, Founder - AAPA Medical Writers Special Interest Group; former Faculty - AAPA Chapter Lecture Series.
30. Kenneth DeBarth, RPA-C, Past President NYSSPA, Past NYSSPA Newsletter Editor, Past Secretary/Treasurer South Dakota Academy of PAs, founding editor SDAPA newsletter, past chair AAPA Professional Practices and Relations Committee, former owner Heuvelton Medical Group, NY.
31. Ryan O'Gowan, PA-C, FAPACVS. Acting Manager, NP/PA Critical Care Workgroup. Program Director Physician Assistant Residency in Critical Care Umass Memorial Healthcare.
32. Frank Rodino, PA, MHS, Past Public Education Chair AAPA, Past NYSSPA President. Currently President and CEO Churchill Communications: A Medical/Scientific Communications Company.



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33. Thomas Roselle, PA-C, DFAAPA past NYSSPA Consultant, PA Entrepreneur, Clinic Owner. Current Secretary, PAs in Otolaryngology Specialty Group.
34. John Sallis, MBA, MMS, PA-C PA consultant -Negotiation management.
35. James Doody, PA-C Director of Pediatrics and Primary Care 1st Health Centers, Assistant Clinical Professor University of Colorado Health Science Center, former Director of Pediatrics Lake Grove School, Editorial Board Member Physician Assistant Magazine, Provider liaison Medical Home Initiative for State of Colorado.
36. Karen Fields, MSPAS, PA-C Founder of Medical Mentoring (medicalmentors.net); Cofounder PAWorld.net.
37. Richard Mayer, PA. Vice President Provider and Network Development. Lenox Hill Hospital, NY, NY.
38. Sharon Bahrych, PA-C, MPH, listed in Marquis's Who's Who of American Women, published author of 60 lay and medical journal articles, state and national CME presenter, co-founder of APAO, clinical trials researcher with a NIH rated grant, currently working on a PhD.
39. George Berry, MPAS, PA-C, DFAAPA. Pediatric Trauma Coordinator Regional Pediatric Trauma Center, Schneider Children's Hospital North Shore-Long Island Jewish Health System.
40. Lisa F. Campo, MPAS, PA, DFAAPA past President NYSSPA. Former Chief Delegate/ delegate AAPA HOD; former Committee member Wagner College PA Program Advisory and Admission Committees; President LCFC-LLC Consulting; Advanced Clinical Physician Associate the Mount Sinai Medical Center; practicing PA 30 years.
41. Kristina Marsack, PA-C, President, Association Plastic Surgery PAs, past-Treasurer, APSPA.
42. John W. Bullock, PA-C, DFAAPA. 2010 AAPA Federal Service PA of the Year Award Winner. Past Chief Consultant to the US Air Force Surgeon General for Physician Assistants, Founding member and past Vice President of PAs in Orthopaedic Surgery.
43. William Gentry, MPAS, PA-C Senior Physician Assistant-Neurology Audie L. Murphy Veterans Medical Center.
44. Harmony Johnson PA-C, MMS Current President, PAs for Global Health.



## Physician Associate: A Change Whose Time Has Come



**CPT Sean Grimes**

**KIA 4 Mar 05**

45. Chris Hanifin, PA-C. Immediate Past President, new Jersey State Society of PAs.
46. Francis Crosby, Jr, PA-C, MPAS. Founding member, United Kingdom Association for Physician Assistants (UKAPA); Member of Pilot Program for PA utilization in UK; Advisor to University of Wolverhampton (UK) PA Training program; AAPA; Delegate or alternate for many years, Publications award winner, 1987; Fellow Member, Society of Air Force Physician Assistants; Past VP of SAFFPA; Past Chair of Nomination Committee; Past Chair of Membership Committee; Past BOD member; Associate Member, Royal College of Physicians Edinburgh; Retired from USAF as Lt Col; Former Commander, Medical Operations Squadron.
47. David L. Patten, PA-C, COL, SP, TXARNG. Deputy Commander for Texas Medical Command.
48. Michael France, CCRC, MPAS, PA-C, Director of Clinical Research, Alamo Medical Research, MAJ USAF Retired.
49. Robert L. Hollingsworth, DHSc, MS, PA-C. Owner, Sole Provider Red Springs Family Medicine Clinic, N.C. Preceptor for the Physician Assistant Programs at Methodist College in Fayetteville, N.C., Duke University in Durham N.C. and East Carolina University, in Greenville, N.C. Active preceptor for several Nurse Practitioner Programs within the state. Former Instructor: Methodist College Physician Assistant Program.
50. James C. Allen, IV, MPAS, PA-C, DFAAPA; Director, Physician Assistant Clinical Training Programs, University of Texas Medical Branch-Galveston/Correctional Managed Care; Former Secretary Bexar County PA Society 2003-2005; Dual Certified Aerospace Physiologist; US Air Force Aerospace Physiologist of the Year 2003; Past President Towner-Shafer Society, US Air Force 1993-1994; Retired US Air Force Major.
51. Michelle Ederer, MA, RPA-C Past President, New York State Society of PAs.
52. Cindy Burghardt, MS, PA-C, Nephrology PA for Renal Associates, San Antonio, Texas.
53. Shepard B. Stone, P.A. Colonel, SP, CTARNG. Aeromedical Physician Assistant. Aviation Task Force- Currently deployed-Kuwait. Physician Associate-Yale Medical School.
54. Charlene Morris, DFAAPA, MPAS, PA-C, Past President AFPPA, CME Chair SPAP, Past AAPA Liaison to AAFP, Author/Lecturer.
55. Jonathan E. Sobel, RPA-C, FAPACVS President-Association of PA's in Cardiovascular Surgery.

## Physician Associate: A Change Whose Time Has Come

56. Geoffrey Hoffa, PA-C, MHS Board Member of the Arizona Regulatory Board of Physician Assistants. First PA Associate member American Society of Transplant Surgeons. Past Chair, Public Relations Committee ASAPA, Current member of the AAPA HOD.

57. Robert M. Chavis, PA Commander / 05 USPHS/Army, Past Chairman Academy of USPHS Physician Assistants, Past Medical Director USMAPS, Delegate UN World Indigenous People Conference, Wolfclan Chief Nottoway/Meherrin/Tuscarora Nations.

58. Keith G. Plummer MPAS, PA-C, DFAAPA Director of Emergency Medicine, Johnston Memorial Hospital, Oklahoma.

59. Joseph A Hlavin PA-C, MS Neurosurgical PA. Former President, Association of Neurosurgical Physician Assistants (ANSPA), 1998 – 2000, 2006 - 2008 AANS Neurosurgeon Editorial Board, American Association of Neurological Surgeons, 5/1/2008 – 4/30/2011. President, Brazos Valley Physician Assistant Association 1/2010 -12/2010.

60. Francine Boullosa, PA-C. Past-president and past legislative co-chair Oregon Society of PAs 1991-2 AAPA-Burroughs-Welcome Health Policy Fellow.

61. Richard M. Bishow, MPAS, PA-C, Lead Physician Assistant, Inova Fairfax Hospital Emergency Department, Distinguished Fellow, AAPA, Emergency Medicine clinician for 32 years, Associate Clinical Professor of Health Care Sciences, The George Washington University School of Medicine and Health Sciences, Associate Professor of Emergency Medicine, The Virginia Commonwealth University School of Medicine, Clinical Instructor of Health Care Sciences, Drexel University College of Health Profession, Paragon Award winner (1st Place) for publishing excellence.

62. Michael A. Banuchi, PA-C, MPH: Founder/Owner, PhysicianAssistantForum.Com/PhysicianAssociate.Com, Board of Advisors for National Association of Physician Assistants. Dermatology, Boca Raton, FL.

63. Edward Ranzenbach, PA-C, MPAS, FAPACVS, DFAAPA Fellow - Association of Physician Assistants in Cardiovascular Surgery (APACVS) Leadership Fellow APACVS , Fellow American Association of Surgical PAs Fellow California Academy of PAs Director-at-Large APACVS Board of Directors, Member Fellow Membership Oversight Committee APACVS Member CME Committee APACVS, Chair - 27th Annual APACVS Winter Educational Meeting Associate Member Society of Thoracic Surgeons.

64. Jose' C. Mercado, MMS, PA-C President- SPAO-HNS. Adult & Pediatric ENT Disorders.



## Physician Associate: A Change Whose Time Has Come

65. Professor Steven J. Sager, MPAS, PA-C, DFAAPA Assistant Professor, Physician Assistant Department Nova Southeastern University - Ft. Lauderdale.
66. Joel D. Bashore, PA-C, MPAS; LCDR, MSC, USN (Ret); PA/NP Education Coordinator, Carilion Roanoke Memorial Hospital Emergency Dept.; Past Vice-President Naval Association of Physician Assistants.
67. Kimberly J. T. Lakhan, MPAS, PA-C, DFAAPA Otolaryngology, Head & Neck Surgery, Facial Plastic Surgery and APN/PA Council Chair SMDC Health Systems, Duluth, MN, Distinguished Fellow AAPA, Fellow and Past Director-at-Large Minnesota Academy of PAs, Fellow SPAO-HNS.
68. Larry Collins, PA-C, DFAAPA, ATC. Instructor, Department of Orthopaedic & Sports Medicine, University of South Florida. USF Sports Medicine and Athletic Related Trauma Institute. United States Olympic Training Program including stints at the 1996 Summer Olympic Games in Atlanta, and at the 2008 Winter World University Games in Torino, Italy.
69. Michael C. Doll, MPAS, PA-C, DFAAPA, FAPACVS. Chair of Quality Care Committee - AAPA. Past President - APACVS. Current Candidate for Director At Large - AAPA Director of Physician Assistants Cardiac Surgery Service Line Geisinger Health System, Danville, PA.
70. Thomas White, JD, MA, PA-C, Past President TAPA, NMAPA, PA Educator.
71. Denni J. Woodmansee, PA-C. PA Advisor to the Under Secretary for Health, U.S Department of Veterans Affairs.
72. Lisa Lanning Lowther, MS, PA-C; Assistant Professor, Medical College of Georgia PA Program; Emergency Medicine and Family Medicine PA for 10 years.
73. Carol S. James PA-C. Lead Physician Assistant. Department of Neurosurgery. The Johns Hopkins Hospital.
74. Richard C. Davis, P.A. Chief PA, RRMCC. 35 years of PA practice. Salisbury, NC.
75. Matthew Andersen, PA-C, MPAS, FAPACVS Department of Cardiothoracic Surgery Virginia Mason Medical Center Seattle, WA.
76. Rudolph (Rudy) Balli, MPAS, PA-C "Physician Associate" (University of Oklahoma) Captain, USAF, Retired. Audie L. Murphy Veteran's Memorial Hospital.
77. Alex K. Harris, PhD, PA-C, Southern Cardiopulmonary Associates, PC, LaGrange, GA; ApolloMD Emergency Physicians, Atlanta.



## Physician Associate: A Change Whose Time Has Come

78. Vee S. Yoong, PA-C, MS, Ph.D. Providence St. Peter Hospital. Emergency Medicine, Olympia, Washington. American Heart Association ACLS Regional Faculty/Course Director/Instructor. Advance Cardiac Life Support - (ACLS-EP) Instructor, Katrina Hurricane Relief Volunteer medical worker, American Red Cross, PA Consultant. Initial groundwork & program design for Pacific University Physician Assistant Program, Forest Grove, Oregon.

79. Reginald L. Smith, PA-C, Past Vice-President and Past Director-at-Large Bexar County PA Society, San Antonio, Texas.

80. David N. Pellin, PA-C, FAAPA; Past Clinical Director Indian Health Service, WellPoint Service Unit, Spokane Reservation, 2007 - 2010; Clinical Preceptor, University of Washington School of Medicine MEDEX Northwest, 2008 - Present University of Washington School of Medicine MEDEX Northwest, Cum Laude graduate, 2005 - 2007.

81. Bob Sammartano, RPA-C Program Director Postgraduate Residency in Surgery for PAs Montefiore Medical Center President Elect AASPA, Chief Delegate for Surgery - AAPA HOD.

82. Lawrence Russell, P.A. Founding President, Society of Air Force PAs. Former Associate Chief of PAs, USAF. PA for 38 years.

83. G. Ken Phillis MPAS PA-C. Past Board member, PAC member, and Legislative Affairs Committee of the Texas Academy of PAs. Retired, United States Army.

84. Glen E. Combs, MA, PA-C Former President of the AAPA. NCAPA Board Member-Chapter President.

85. Cheryl E. Gregorio, PA-C, MPAS, DFAAPA; Paragon winner Federal Services PA of the Year and Veteran's Caucus PA of the Year ; 28 years practice; Degree as a Physician Associate, OU.

86. Jackson R. Dobbins, Colonel, USAF, Ret (2009) Med College of GA Class of '78 Fellowship, Montefiore Med Centre, NYC - Emer Med /79-80. 1st AF PA on operational support flying status, AFSOC (Graduate of Flight Surgeon/APA School, Ft. Rucker 1997), 1st PA as Combined Special Operations Task Force Surgeon Operation DESERT THUNDER. 1st PA as Medical Group Commander in USAF. Montefiore Alumni Association.

87. Jo Ann Cutler Friedrich, P.A.-C Stanford University, 1976 - Author of The Pre-Menstrual Solution, Arrow Press, Inc. 1987 and Sleep Matters, Bright Books, 1995. Over 350 national and regional TV and radio programs, Published in USA Today and the Chicago Tribune.



## Physician Associate: A Change Whose Time Has Come

88. Steven Engelberg, PA-C, PhD. University Medical Center, Las Vegas, NV Dept. of Emergency Medicine, VP / Founder National Association of Physician Assistants, Past President Nevada Academy of Physician Assistants. Assistant Professor, Touro University, NV.

89. Herve Poulard, PA-C Medical Attaché'. US Embassy Santo Domingo.

90. Brian R. Bea, APA-C, MPAS. Aeromedical P.A. LTC, Oregon Army National Guard 16 years of experience in Family and Emergency Medicine.

91. Terry Mathews, Lt Col, USAF, BSC, PA-CI. Pres-Elect, Society of AF PAs 1998 AMSUS PA Award winner 1998 SAFPA Wheaton Award winner 2005 Air Mobility Command PA of Year.

92. Ellen Britt, PA, EdD. Online Marketing Expert and Consultant and Co-founder of MarketingQi.com. Ellen specialized in Emergency Medicine/Urgent Care and Occupational Medicine for more than two decades, graduate of one of the first specialty PA training programs in the country, the Robert Wood Johnson Emergency Medicine Postgraduate Program at Maine Medical Center, Portland. She lives and works near Atlanta, Georgia.

93. Jennifer Moore, PA-C past AAPA Board Member. Past President NYSSPA. 1975 Graduate of Stony Brook Physician Associate Program.

94. Ed Friedmann, PA AAPA Past President. Past Chair, Iowa PA Regulatory Board. Federally Certified Rural Health Clinic PA for many years.

95. Jeffery Nicholson, PhD, PA-C, DFAAPA. President American Academy of PAs in Legal Medicine, Board Member, Wisconsin Academy of PAs.

96. James Taft, MPAS, PA-C. JAAPA Board Member, CHSC Member and QCC Member.

97. George (Rick) Hillegas, PAC, MPH. First PA Class GW University. AAPA Health Policy Fellow 1992, Retired US Coast Guard PA.

98. Bud Shelton, PA-C past President North Carolina Academy of PAs. Graduate Duke Physician Associate Program. 30 years Pulmonary Medicine, Ambulatory Surgery 15 years, Durham NC.

99. Glen Sikes, PA-C SUNY Stony Brook, 1977 Former Director of Surgery, Lower Florida Keys Health System, Key West Florida. 33 years combined ER/OR experience. Presently in primary care in rural North Carolina.

100. Ernest W. Edmonds, PA-C, MPAS. SAFPA President - 1983-84. SAFPA Secretary / Treasurer 1985 - 1993(?). Program Director, USAF PA Program 1988 - 1991. Clinic Director, VA Outpatient Clinic (Contract) 1995 - current



## 1st Air Cavalry Brigade Received the Outstanding Achievement Award

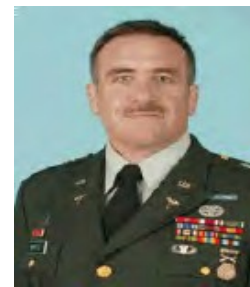
The following article was modified from its original content first seen in the December 2010 Corps Connection and comes courtesy Major Kathy Schultz, Executive Officer, Army Medical Specialist Corps.

**The article was submitted by CPT William H. Edmonds, APA-C**

Upon redeployment from OIF 09-10, the following 1st Air Cav BDE APAs earned the Society of US Army Flight Surgeons Aeromedical Out-standing Achievement Award:



MAJ Earl K. Downs



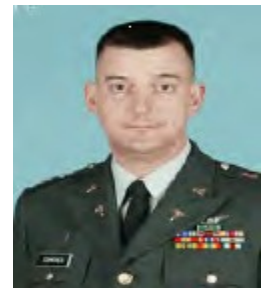
MAJ Rick E. Whitley



CPT Michael A. Black



CPT Jeffrey D. Garberich



CPT William H. Edmonds

This award is described below:

Outstanding Achievement Award. This may be presented to any Army Flight Surgeon, Aeromedical Physician Assistant, or Associate Member, at any time when the Awards Committee feels it is justified. It may be used to recognize a specific action or achievement. More than one presentation may be made during the year, and there shall no requirement to make the award during any year.

Congratulations to these outstanding PAs for their contribution to Army Aviation Medicine and the Global War on Terrorism.

## Rangers Get RAW to Enhance Performance

In 2006, the 75th Ranger Regimental Commander (COL Paul LaCamera) tasked CPT Ray Sterling (Regimental PA) with developing a comprehensive human performance program.

As the concept for RAW emerged, three objectives were identified to include controlling injuries, improving performance, and standardizing Ranger fitness training. Initially, the three Ranger battalions had several years of experience with civilian strength and conditioning coaches. These coaches came from diverse backgrounds and this was reflected in their approach to training. Despite all three battalions having identical mission requirements, the training varied significantly. In addition, training varied by individual squads. If the squad leader was a runner— the squad ran— if the squad leader was a lifter—the squad lifted. The Regimental Commander sought a program to standardize training for all Rangers to ensure that each Soldier was fully capable of executing all physical requirements. CPT Sterling (now retired MAJ) developed a team approach to develop this program. The initial team included battalion strength coaches and physical therapists. Later, the Regiment hired a Regimental physical therapist, occupational therapist, and dietician. This team provided a critical knowledge base and centralization to provide oversight for battalion level physical therapist who coordinated unit programs.

The following article appeared in the latest (December 2010) SP Corps Connection and was acquired from the “Bayonet” and written by Vince Little (November 18, 2010). This article provides insight into the highly successful RAW Program.

**FORT BENNING, Ga.** - The 75th Ranger Regiment is always looking for the Army's best Soldiers. Once they become Rangers, the unit wants to keep them sharp for their intense training and deployment tempo. The regiment has been continuously deployed since Sept. 11 and Ranger fitness has been critical to its success, leaders said.

Through its Ranger Athlete Warrior program, the regiment uses the latest concepts in functional fitness, resilience, sports medicine and nutrition to optimize human performance within the ranks. RAW has been around since 2006, officials said, but leaders are emphasizing the rewards and sinking more resources into the system to maximize effectiveness.



**Sgt. John Rossmiller of the 75th Ranger Regiment drags a 185-pound pulling sled during an assessment Wednesday. He's seen wearing a Mobile VO2 Assessment Unit, which monitors oxygen efficiency proportionate to activity level.**

"Rangers are always looking for an edge to get better, faster and stronger - they already have that elite athlete mentality," said Maj. Robert Montz, the regimental occupational therapist and officer in charge of the RAW program. "There are a ton of resources out there. We thought, let's get some subject matter experts on board who know this stuff and make sure our Rangers are truly doing the right things to become more elite." The program is built around four pillars: functional fitness, performance nutrition, mental toughness and sports medicine. It incorporates multiple disciplines and takes a holistic approach to keeping Rangers in the fight, factoring in the extreme environments they routinely operate and train in.

Montz said the components address every need for optimal Ranger performance - and they're not just a matter of working out hard. Regimens must be appropriate to the physical requirements, fueled by sound nutritional practices and designed to prevent avoidable "overuse" injuries, he said, with the mind fully engaged. Any injuries that do surface should be addressed promptly and thoroughly. "That's the whole continuum ... everything a Ranger needs to be operational. This program brings all those dynamics into one," he said. "There isn't a recipe or formula online for becoming a better Ranger. For NFL and college players, there's a nice science out there already for how a linebacker can become a better linebacker. (RAW) is specific for the mission sets Rangers need to do in combat operations. "We knew we needed something a little more robust than traditional (physical fitness test) tasks."

Among recent moves, the regiment brought in Dr. Travis Harvey to serve as director of human performance. The RAW staff also includes Capt. Nick Barringer, the regiment's first Ranger Dietitian, and retired Lt. Col. David Meyer, a physical therapist and the unit's sports medicine director. In addition, each battalion now has a strength and conditioning coach, along with a physical therapist, physician assistants and surgeons. "There's a vast amount of information available. We help them filter it for their own program integration," Harvey said. "Since a Ranger's schedule is already so jam-packed, we want to optimize their time and get them to train smarter and more efficiently. This is specifically tailored for Rangers. "There are a lot of good training programs and components online, but putting it all together for Rangers is just not out there. We want (RAW) to be the pre-eminent program so they don't need to go anywhere else." The team of therapists and healthcare providers spread the program's principles by conducting five-day training sessions with squad and team leaders throughout the regiment.

Soldiers in the Ranger Assessment and Selection Program also get an overview. In a joint venture with the Directorate of Family and Morale, Welfare and Recreation, the 75th Ranger Regiment provided equipment to Audie Murphy Athletic Center for tactical fitness training. The facility features pulling sleds, ladders, ropes and other apparatus designed around power, speed and agility drills. The gym is undergoing renovations and not scheduled to reopen until March, but it's normally available to all post personnel.

In 2008, the regiment began doing a 10-event RAW assessment to measure the program's impact and functional fitness level of its Rangers before and after combat deployments. It's a physical fitness test loaded with Ranger tasks in uniform to evaluate performance levels. Facilitators said it's a better gauge than the APFT and a great tool that's been shared with other units. Montz said commanders use the data to make adjustments and help map out physical development for missions. "The RAW program is constantly evolving to reflect the current mindset, operations and conditions," he said. "It's an ongoing process to make sure we're delivering the most optimal, up-to-date program for our Rangers and leaders." Chronic issues such as back, shoulder and knee ailments affecting veteran Rangers might have been averted if today's training techniques, methodology and approach to PT had been applied in past decades, Montz said. Harvey said new science and research are emerging all the time. "It can be difficult to determine what a Ranger should take away from a particular research study. That's where we step in," he said. "The end product has to be what it's going to do for a Ranger."

Below is a description of the overall intent of RAW:

The Ranger Athlete Warrior program addresses four objectives through the components of functional fitness, performance nutrition, mental toughness and sports medicine:

- Achieve a level of physical fitness that is commensurate with the physical requirements of Ranger missions.
- Understand and choose sound nutritional practices.
- Employ mental toughness skills to enhance personal and professional development. The regiment's occupational therapist and psychologist coach Rangers on the mind-body connection in order to optimize performance.
- Receive screening, education and skills for injury prevention and "prehabilitation" that prompt effective and thorough treatment through "rehabilitation" of injuries if and when they do occur.

For more information about the Ranger Athlete Warrior program, go to <https://www.benning.army.mil/75thranger/content/physical.htm>.

## Components of RAW



# PREDEPLOYMENT TRAINING OPPORTUNITIES



In 2008, the Center for Predeployment Medicine was formed at Fort Sam Houston. This course prepares medical specialists for deployment with training that covers everything from battlefield first aid to working in combat support hospitals. These courses are supervised and training is led by active duty and retired Army physician assistants and medics. During the last calendar year a total of over 6,000 personnel were trained by the center.

The CPDM conducts four courses that were previously offered through various departments at the AMEDD Center and School — some of which had curriculum redundancy among them. Having the courses managed by a single center allows for greater support and frequency of courses, and training which used to be optional will become mandatory, CPDM officials said.

The courses are offered to combat medics, physician's assistants, senior medical noncommissioned officers, physicians and nurses. The training prepares Soldiers for what they will experience in the field, said Armand Fermin, course coordinator for the Brigade Combat Team Trauma Training and Military Transition Team Medical Course at the CPDM. "The first time a combat medic sees a casualty on the battlefield, they need to be confident and competent in their ability to do their job," said Fermin, a retired first sergeant. "We provide that confidence and competence."

The following courses are offered by the CPDM.

## Brigade Combat Team Trauma Training

The five-day BCT3 is for combat medics assigned to brigade combat teams. The training focuses on tactical combat casualty care, which includes controlling bleeding, treating chest wounds and their associated problems, and clearing airway obstructions, said retired Army PA Casey Bond, a program manager at the center. Much of the training is performed in the field in battlefield and urban environments, according to BCT3 literature.

## Military Transition Team Medical Course

The MiTT training is for the team's medical NCO. MiTTs are teams of 12 to 20 Soldiers who are imbedded with Iraqi or Afghan security forces as trainers and advisers. The eight-day training covers tactical combat casualty care as well as working as an independent medical provider. The medical NCOs provide care for their teams and train their foreign counterparts as combat lifesavers, Fermin said.

## Tactical Combat Medical Care Course

The TCMC course is geared toward PAs, doctors, nurse practitioners and senior medical NCOs who will be assigned to battalion aid stations and medical companies. The five-day course is a mix of didactic and hands-on realistic scenarios to prepare providers to go downrange, said Maj. Shon Compton, deputy director for the center. The course can be taught at the providers' home units or at Fort Sam Houston, he said.

## Joint Forces Combat Trauma Management Course

The five-day JFCTM Course is designed for physicians, nurses, senior medics and PAs who will be stationed at combat support hospitals. Course topics include advanced principals of critical care, stabilizing and transporting patients, and surgery. The following pages discuss these courses in detail. The goal of these articles is to provide military PAs with information regarding predeployment courses for PAs, battalion physicians, and combat medics.

Major Jimmy Cooper (MD) is the director and Major John Detro, the deputy director of the CPDM.

## Military Transition Team (MiTT) Medical NCO Course



*“Great course. Scared coming into the course especially since it had been about four years since doing medical skills. I feel confident now to go down range and treat casualties.”*

68W



The MiTT Medical NCO Course is one of four programs which fall under the Center for Predeployment Medicine. Like all other CPDM programs, MITT is overseen by a physician assistant. Major Michael Chambers (PA-C) is the OIC and SFC William Mudd is the NCOIC of the MiTT Course. Below is a description of the program.

MiTT course is designed to provide the medical Non-Commissioned Officer (NCO) the tools and knowledge to function in austere environments without the immediate support of echelon I or II medical providers. The training was established in 2005 for that medic that was assigned as the sole medical asset to his team. The medic’s responsibility was not only to train his team on CLS skills and the foreign military medics, but more importantly provide medical treatment and respond to any trauma for his teammates.

The course consists of an eight day footprint consisting of limited primary care and trauma training. The curriculum uses the most current Tactical Combat Casualty Care (TC3) Guidelines and lessons learned to provide the individual the cutting edge of information available. The didactic portion is enhanced with practical exercise and hands on training. There is a day of surgical skills lab with focus on life saving emergency surgical procedures and a culminating event of trauma lanes which takes the student through the care under fire, tactical field care and tactical evacuation phases of care. Course completion awards 61 Continuing Education Units (CEU’s) which is a requirement for maintaining their EMT licensure.

Student enrollment varies with United States Army personnel (Regular Army, Army Reserve and National Guard), Navy Independent Corpsman and Aerospace Medical Technicians all scheduled to deploy as part of Agricultural Business Development teams, Civil Affairs teams, Provisional Reconstruction Teams (PRT) or MiTT.

We instruct 12 classes of 40+ students each this year ensure that the graduate understands the fundamentals of TC3. Instructors for the course range from active military and retired PA’s or senior 68 W’s with combat experience that understand the situation these warriors are going into. This course refreshes and updates the trauma, resuscitative skills and basic medical skills of front line medic prior to deployment which greatly enhances the outcome of their patients. A recent directive from the Army Surgeon General has mandated this course as pre-deployment training for all Army medical personnel deploying to MiTT or PRT assignments. Students or supervisors may sign up for this course by sending a DA3838 to Armand Fermin at [armand.fermin@AMEDD.army.mil](mailto:armand.fermin@AMEDD.army.mil).

**Courtesy of MAJ Michael Chambers**



*"Superb course,  
superb  
organization,  
relevant and  
highly valuable  
content - real  
"nuts and bolts",  
without dogma."  
General Surgeon*

## Joint Forces Combat Trauma Management Course

The Joint Forces Combat Trauma Management Course (JFCTMC) is a dynamic training program consisting of a series of lectures & labs designed to familiarize Combat Support Hospital (CSH) medical personnel with core Tactical Combat Casualty Care (TC3) principles, and to review the latest clinical practice guideline (CPG) updates and nursing/surgical techniques for managing combat casualties in an echelon III environment. Originally begun in 2008 and providing the same surgery-oriented training to all CSH personnel, JFCTMC has evolved drastically and now includes separate tracks for nurses and providers, as well as breakout sessions tailored for each major provider role within the CSH.

The course is five days long and geared toward Surgeons, Physicians, Physician Assistants, Nurse Practitioners, Nurses, and 68WM6s (on a space-available basis) providing care at a CSH/level III environment. Although designed around an Army medical operational model utilizing the latest information and lessons learned from current theatres of operation, medical personnel from the other armed services deploying to theater hospitals are welcome to attend as well.

The early didactic curriculum incorporates the most current theater CPG's with practical advice from veterans of combat medicine, while the later role-specific labs and breakout sessions include: Emergency Nurse Pediatric Course (ENPC), Advanced Burn Management Course (ABLS), Transport Nurse Advance Trauma Course (TNATC), Advanced Trauma Operative Management (ATOM), Advanced Surgical Skills for Exposure in Trauma (ASSET), TC3 lab, Emergency Procedure lab, Ultrasound lab, Anesthesia lab, and a tactical field nursing exercise. Advanced Trauma Life Support (ATLS) certification is pending.

While there are currently no CME/CEU credits awarded for attending JFCTMC, many of the sub-courses grant them upon successful completion. Student enrollment into JFCTMC is a mixture of US Army (active duty, Reserve, and National Guard) personnel assigned to various CSH's, with occasional Navy and Air Force students attending as well. You must be on orders to deploy within 6 months to be eligible for this course, and the Army Surgeon General has recently issued a directive requiring all Army medical personnel to receive pre-deployment training starting in FY 2010.

We offer six classes each year in San Antonio, TX, held every other month. The course is given conference-style, with the majority held in a local area hotel and utilizing the lab/training facilities located in AMEDDC&S, BAMC, and Camp Bullis. Our instructors are subject matter experts in their medical specialties with recent deployment experience, and travel from locations across the country to teach at JFCTMC. For more information about JFCTMC including the available course dates, please refer to our website <http://www.cs.amedd.army.mil/deployment/jointtraumaPage.aspx> or contact our staff at (210) 808-4929.

**Courtesy of Captain Daniel Comeaux, OIC JFCTMC**

## Tactical Combat Medical Care Course



*“I will tell you that BCT3 and TCMC were right on! The types of saves are absolutely amazing.”*

LTC Michael D. Wirt  
CTF Strike Surgeon  
101st AB DIV

TCMC is a dynamic training program designed to provide the pre-hospital medical provider the skills and knowledge in evaluating, resuscitating and managing the combat casualty. To date there is no equivalent training model for the Battalion level provider, either Physician or Physician Assistant (PA). Started in 2003 by two combat experienced Physician Assistants who saw a need for the training, the course was originally for newly graduated PA students with no trauma background but facing imminent combat deployments to Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan in support of the Global War on Terrorism.

The course is five intense days geared towards Physicians, Physician Assistants, Nurse Practitioners and senior medical Non-Commissioned Officers (NCOs) providing care at the line unit level in the pre-hospital environment. The curriculum uses the most current Tactical Combat Casualty Care Guidelines and is heavily weighted with practical exercise and hands on training using currently employed class VIII supplies and equipment. There are two days of surgical skills lab with focus on life saving emergency surgical procedures. The course also awards 46 hours of category I CMEs for providers just before deployment to help with maintaining credentials and licensure.

The course was originally run by just 2 PAs teaching approximately 12 classes per year of 20 PA OBC students each in borrowed classrooms on a shoestring budget. It has grown to a staff of 16 with over 30 years combined deployed wartime experience in the current conflict and has widened our target audience to include line unit Physicians, hospital Physicians tasked to deploy with line units under the Professional Officer Filler System (PROFIS), Nurse Practitioners and senior treatment platoon NCO's. The course has also included Navy and Air Force medical providers deploying in Provisional Reconstruction Teams (PRT) and Military Transition Teams (MiTT) to both theaters. These providers then teach host nation medical providers further deploying our “train-the-trainer” effort and rebuilding those country's military medical capabilities.

We are scheduled to teach 23 classes of 30 students each this year using a \$4+ million dollar budget. The course focuses on initial lifesaving care at the point of injury, emergency procedures, and resuscitative care in the pre-hospital environment. This course refreshes and updates the trauma and resuscitative skills of front line medical providers just before deployment which greatly enhances their readiness and has a direct effect on the initial treatment of wounded soldiers and civilians. A recent directive from the Army Surgeon General has mandated this course to be required pre-deployment training for all army providers going to echelon I/II facilities starting in FY2010. Students pending deployment or BOLC may sign up for this course by contacting Mr. Charles “Al” Proulx at [Charles.a.proulx@AMEDD.army.mil](mailto:Charles.a.proulx@AMEDD.army.mil). Additional Information can be found at <https://www.us.army.mil/suite/files/6030837>. **Courtesy Major Brett “Smitty” Smith**



## Brigade Combat Team Trauma Training Course

Reports from OIF/OEF laud the medical performance of our 68W Soldier Medics. Much of this praise is due to the premier mobile training team BCT3, a component of AMEDDC&S's Center for Pre-Deployment Medicine. Current OPTEMPO makes it difficult for units to execute or standardize trauma training required for 68Ws assigned to Brigade Combat Teams scheduled for deployment. Those assigned to deploying units are often unable to train or sustain critical tactical combat medical skills. The AMEDDC&S responded with courses designed to assist the units with this problem. In 2008 the official Center for Pre-Deployment Medicine continued to develop and improve the original efforts of DCMT which began in October 2006. As of October 2009, BCT3 has become mandatory for a minimal of ninety percent of all deploying Medics in a Brigade Combat Team and has the critical mission for providing trauma training within six months of departure. BCT3 is ran and funded with minimal cost, logistics, and manpower to the trained unit and the Medics earn 40 CEUs for their EMT recertification upon completion of the five day course. More importantly, the Medic completes the course with the exposure of realistic casualty scenarios and confidence in their skills (trained and/or refreshed) which will improve their abilities to save lives on the battlefield. A BCT3 Team is composed of 18 68W NCOs and one Physician Assistant and trains up to 120 Medics per week. The course incorporates specific training in the concepts of tactical combat medical care which emphasizes realistic application of Tactical Combat Casualty Care (TC3) principles (care under fire, tactical field care, and tactical evacuation care). Course content is based upon the lessons learned from theater, the injury patterns of combat casualties (focus on preventable causes of death) and the constraints of care given in the extraction, treatment and evacuation in a variety of operational combat settings (rural/urban). BCT3 incorporates a crawl, walk, run approach where didactic instruction, skill stations and lane training culminate to a final combat speed execution of realistic casualty care lane scenarios. Utilizing assigned medical equipment, supplies and evacuation capabilities, the Medic must execute to standards the appropriate care at the appropriate time. Medics have the opportunity to utilize the latest field medical equipment and must actually perform treatment (no simulation or verbalization but actual performance with supplies at hand). Didactic classes include TC3 overview, Airway and Burn Management, Extremity and Chest Trauma, Traumatic Brain Injury (TBI) and PTSD Identification and Interview, Humanitarian/Detainee Care, Removal of Human Remains, Pediatric/Geriatric and OB-GYN Concerns in Trauma. Practical exercises (skill stations and lane training) include triage, rapid trauma assessment, airway management, treatment of extremity trauma (including tourniquets and hemostatic agents), treatment of chest wounds, splinting and dressing, extraction and evacuation, packing of medical treatment bags, life-saving emergency surgical skills, and the evaluation and management of mass casualties utilizing simulated combat casualty scenarios. BCT3 now trains National Guard and Reservists and other Medics who fall outside the normal BCT structure. The vision is to convert the "pre-deployment" description to "sustainment" training to ensure the quality of future training for the Combat Medic. Since the first BCT3 training event in the fall of 2006, the program has trained over 10,000 Combat Medics on every major FORSCOM installation and all the combat divisions in CONUS/OCONUS. Brigade medical operations personnel may sign up medics by contacting program manager Armand Fermin at [armand.fermin@AMEDD.army.mil](mailto:armand.fermin@AMEDD.army.mil). **Courtesy MAJ Ken Brodie, SFC Earl Lewis and SFC Christopher Kane**



*"I will tell you that BCT3 and TCMC were right on! The types of saves are absolutely amazing."*

LTC Michael D. Wirt  
CTF Strike Surgeon  
101st AB DIV



## SAPA Director of US Army Retired PAs

**From Casey Bond, Program Manager, Center for Predeployment Medicine**

Greetings from sunny San Antonio! Unfortunately, I was unable to attend the conference last year. First one I've missed in over 20 years and I missed seeing all of you. Last year was also the first time in 14 years I haven't served on the BOD. Actually, I thought that was a good thing. I felt our organization was in need of an infusion of new blood and since mine is anything but new I opted not to run for any office. Lo and behold! You know how when you don't show up to a meeting and you end up nominated for something? That's exactly how I became Director of US Army Retired Component (actually Paul Lowe called me and asked if I'd agree to run).

As you all know, Paul does an excellent job as Membership Director. Let me add to his efforts by asking everyone to encourage any known retired Army PA who is not currently a SAPA member to become one. Strength in numbers!

If you are a retired Army PA and a SAPA member and you have concerns or issues you would like to see addressed you may contact me at [caseybond@amedd.army.mil](mailto:caseybond@amedd.army.mil) and I will do my best to assist you in raising those concerns.

If you are interested in an instructor job in San Antonio, the following job will be opening soon. This position will be primarily as an instructor assigned to the Military Transition Team NCO course, one of four different courses in the Center for Pre-deployment Medicine. In addition to the salary range listed below, there is the possibility of recruitment incentive of up to 25% of base salary contingent on background and experience level, subject to approval by higher headquarters.

Position: PHYSICIAN ASSISTANT (INSTRUCTOR), GS-0603-12

Salary: \$68,809 - \$89,450 Annual

Place of Work: USAMEDD CENTER AND SCHOOL, ACADEMY OF HEALTH SCIENCES, OFFICE OF THE DEAN, FORT SAM HOUSTON, TX (San Antonio)

Position Status: This is a 1 year TERM position. -- Full Time

Number of Vacancy: 1



## SAPA Director of US Army Retired PAs

**Duties:** Serve as an NCCPA Certified Physician Assistant instructor, subject matter expert, focusing on teaching combat trauma care delivery at levels I/II. Prepare and conduct lectures, practical exercises and small group instruction in the tenets of tactical combat casualty care, cardiac life support, rapid trauma assessment of patients, medical and minor surgical care to combat casualties in a field environment. Develop/prepare lesson plans, instructional materials and program evaluations. Utilize knowledge of adult education theories and instructional methods to meet AHS, AMEDDC&S and U.S. Army Training and Doctrine Command (TRADOC) requirements in TRADOC 350-70. Keep informed of new procedures, techniques, and information regarding combat trauma management through attending professional meetings, scientific conferences, symposia, congresses, and other professional events.

**About the Position:** The work requires some physical exertion that includes standing in front of a classroom for period of 2 or more consecutive hours, moving between equipment and students in the clinical laboratory setting, and lifting of some moderately heavy items to include patient simulators and the positioning of real patients during the special population practical exercises. The work requires normal hearing in at least one ear. The work requires moderate risks or discomforts that require special safety precautions to prevent exposure from contagious diseases.

**\*SPECIALIZED EXPERIENCE:** Candidates for this position must show in their resume that they meet the minimum qualifications and have one year of specialized experience at the next lower grade level or equivalent under the General Schedule (GS) or other pay systems as an NCCPA certified physician assistant teaching and/or instructing students in the delivery of medical and/or surgical care.

**\*GS-12 and above:** One year of experience directly related to the occupation and equivalent to at least the next lower grade level. There is no substitution of education for experience at this level.

**\*One year of experience in the same or similar work equivalent to at least the next lower grade or level requiring application of the knowledge, skills, and abilities of the position being filled.**

**\*Only degrees from an accredited college or university recognized by the Department of Education are acceptable to meet positive education requirements or to substitute education for experience.**

**\*Demonstrated work experience that equipped the applicant with the particular knowledge, skills, and abilities to successfully perform the duties of the position, and that is typically in or related to the work of the position to be filled.**

**\*The related work experience must have been equivalent in difficulty and complexity to the next lower grade level.**



## SAPA Director of US Army Retired PAs

\*Ability to communicate orally and in writing.

\*Foreign education must be evaluated for U.S. equivalency in order to be considered for this position. Please include this information in your resume.

\*The experience described in your resume will be evaluated and screened for the Office of Personnel Management's basic qualifications requirements, and the skills needed to perform the duties of this position as described in this vacancy announcement. Resumes are rated using a numeric rating procedure. Qualified candidates will be assigned a raw score between 70 and 100 based on possession of job-related skills. Additional points for veterans' preference will be added to the raw score, as appropriate.

Other Information: <https://cpolwapp.belvoir.army.mil/public/forward/VAB?id=otherInformation>>  
(Click on Other Information)

\*To successfully claim veteran's preference, your resume/supplemental data must clearly show your entitlement. Please review the information listed under the Other Requirements link on this announcement or review our on-line Job Application Kit.

Selection is subject to restrictions resulting from Department of Defense referral system for displaced employees.

\*The Department of Defense (DoD) policy on employment of annuitants will be used in determining eligibility of annuitants. The DoD policy is available on <http://www.cpms.osd.mil/ASSETS/E8AB932EA1E44617BAC7222922E42A62/DoDI140025-V300.pdf>

Salary includes applicable locality pay or Local Market Supplement.

\*In accordance with section 9902(h) of title 5, United States Code, annuitants reemployed in the Department of Defense shall receive full annuity and salary upon appointment. They shall not be eligible for retirement contributions, participation in the Thrift Savings Plan, or a supplemental or predetermined annuity for the reemployment period. Discontinued service retirement annuitants (i.e., retired under section 8336(d)(1) or 8414(b)(1)(A) of title 5, United States Code) appointed to the Department of Defense may elect to be subject to retirement provisions of the new appointment as appropriate.

\*Payment of Permanent Change of Station (PCS) costs is not authorized, based on a determination that a PCS move is not in the Government interest.

\*Temporary Duty (TDY) travel is 15 percent.



## SAPA Director of US Army Retired PAs

\*Other Advantages: The spirit of Texas is captured in San Antonio retaining its sense of history and tradition, blending sounds/flavors from Old Mexico to the Deep South. The Alamo is located in downtown San Antonio. The River Walk offers much to the tourist; side walk cafes, restaurants, as well as the nightclubs and hotels. Children can enjoy San Antonio's Children's Museum, Magic Theater, and Brackenridge Park. San Antonio also offers two major theme parks, Sea World of Texas and Six Flags Fiesta Texas.

### Other Requirements:

\*Must be able to obtain and maintain a Secret security clearance.

\*You will be required to provide proof of U.S. Citizenship.

\*If selected, official college or university transcript must be submitted.

\*License/Certification: National Commission on Certification of Physician Assistant NCCPA Certification.

\*Direct Deposit of Pay is Required.

\*Failure to provide all of the required information as stated in the vacancy announcement may result in an ineligible rating or may affect the overall rating.

\*One year trial/probationary period may be required.

### How to Apply:

\*Resumes must be received by the closing date of this announcement.

\*Self-nomination must be submitted by the closing date. Applicants wishing to withdraw from consideration may contact the Central Resume Processing Center at (410) 306- 0137 or [apli-canthelp@cpsrxtp.belvoir.army.mil](mailto:apli-canthelp@cpsrxtp.belvoir.army.mil).

\*Resume must be on file in our centralized database.

\*Announcements close at 12:00am (midnight) Eastern Time.

Point of Contact: Central Resume Processing Center, 410-306-0137, [apli-canthelp@cpsrxtp.belvoir.army.mil](mailto:apli-canthelp@cpsrxtp.belvoir.army.mil)

If interested, feel free to contact me at [jan.bond@amedd.army.mil](mailto:jan.bond@amedd.army.mil) or [Casey.bond@us.army.mil](mailto:Casey.bond@us.army.mil).

Tel. 210-557-6641 regarding the status of the pending announcement.

Thanks. I look forward to seeing you all in April.

Casey Bond



## CoTCCC Needs a Few Good Medics!

**From LTC (Retired) Don Parsons, former Director, Interservice PA Program (IPAP)**

The Committee on Tactical Combat Casualty Care is looking for medics to come and present a medical situation they were involved in during their most recent deployment. This group is made up of medical professionals from all services who make recommendations on battlefield medical care principles and equipment destined for the battlefield.

It is important that we hear from those who are using these principles and practices first hand. In addition, it is important that we know what types of equipment the first responders are equipped with and how well it is performing at the point of injury.

These medics will be asked to present a casualty scenario they were involved in, and describe the who, what, when, where, and why of the incident. These presentations are usually 15-20 minutes in length, and have a few minutes for questions at the end. There is a prescribed format for presentation.

Any PA who has a medic who would be interested in presenting their experiences should contact Frank Butler [Frank.Butler@med.navy.mil]. Frank Butler's article "Tactical Combat Casualty Care in Special Operations" is a seminal article that has transformed the way military medicine is trained and performed.

The committee will provide all expenses to the next committee meeting .

This is an excellent chance for medics to present their experiences to a group that is directly involved in making recommendations to improve casualty care on the battlefield.

Thanks

Donald L. Parsons, PA-C, MPAS

Department of Combat Medic Training

Ft. Sam Houston, TX 78234-6115

210-221-5235 DSN 471-5235

**This is an outstanding opportunity for medics to have their stories told so their insight can be used to lead future training, medical equipment procurement, and medical operations planning.**



# Medical Equipment Survey

**From LTC (retired) Don Parsons.**

Don Parsons is conducting a survey on medical equipment. Please answer the following questions and forward them to Don at [donald.parsons@AMEDD.army.mil](mailto:donald.parsons@AMEDD.army.mil)

## MEDICAL EQUIPMENT QUESTIONNAIRE

During your last deployment was there any medical equipment you used in treating patients that worked well or that worked poorly?

What tourniquet did your unit use?

Was there another tourniquet your unit used?

What type pressure bandage did your unit use?

What type chest seal did your unit use?

What type I/O device did your unit use?

What type IV fluid did your unit use?

Any other special equipment your unit used in patient care?



## Update Battalion Medical Officer Course (BMOC)

**By Major John F. Detro, Deputy Director, Center for Predeployment Medicine**

During recent conversations with multiple battalion, brigade, and division commanders, I have been struck by a common theme. These individuals state the change in selection for the Interservice Physician Assistant Program (IPAP) away from medics toward individuals of any specialty, many without any medical experience has led to a much “greener” PA. One Brigade Commander from the 101st Airborne Division personally told me, “they have never been medics or worked with a PA.” He went on to say, “How do they know what right looks like.” He confided that he felt less than comfortable deploying with a brigade having only one PA with prior medical experience. After speaking to several senior leaders like him, I decided that it is our responsibility as fellow PAs to bring these new providers up to a level needed to be ready to assume responsibilities in a battalion or brigade aid station. As the deputy for the Center for Predeployment Medicine (CPDM),

I have been working with my fellow unit PAs (TCMC) to develop a course to assist in this task. After serving as the 65D BOLC Track advisor, I determined that all the courses taught during the first week of track training could be transferred from the classroom to the aid station. Currently, the second week of BOLC track training is TCMC. Along with TCMC PAs, we have begun development of two courses of action—either a one or two week course. If the course is one week it will precede TCMC. If two weeks it could follow TCMC or be conducted independently. In addition, there will need to be courses to capture officers who will not attend the AMEDD BOLC as they have attended BOLC in their previous branch. Currently, instructors have developed lesson plans, power point slides, course critiques, and the Student Evaluation Plan. A decision paper is nearly complete and a cost analysis determination is underway. Currently, the plan calls for employing TCMC PAs to run both programs. However, in the future the two courses should stand alone with their own personnel and mission. Below is a generic description of the BMOP Course:

**Purpose:** Provide newly assigned battalion physician assistants (potentially physicians) medical officers with the skills and tools necessary to perform successfully as special staff officers.

**Rationale:** Field commanders have recently expressed a concern regarding the new Army PA. One Colonel stated, “Many of these men and women have either not been medics or have not been involved in military medicine in any form.” He went on to say, “They don’t know what right looks like.”

**Faculty:** TCMC staff and potentially other SP officers.

**Audience:** Physician Assistants and potentially physicians and nurse practitioners assigned to Role I/II units.

**Curriculum:** The course will be one to two weeks in length and would replace BOLC branch track training. All students will be instructed on medical planning, medical briefing, use of communications equipment, use of medical equipment (SKOs), employment of information technology (MODS, ALHTA, CHCS), medical logistics, aid station operations, and training of medics and first responders.

The CPDM hopes to conduct three pilot courses this spring to determine the feasibility, requirements, and needed duration for the program.

“One brigade commander from the 101st stated, they have never been medics or worked with PAs.... How do they know what right looks like?”

# SAPA CONFERENCE 2011



Hello everyone, the 32nd Annual SAPA PA Refresher Course is rapidly approaching, April 11 through April 15, 2011.

Registration is now open for the conference.

The initial flyers have been sent out. If you have not received one, you may print one from the website, [sapa.org](http://www.sapa.org).

The link to the web page for the registration form is: <http://www.sapa.org/Registration%20Form%202011.pdf>.

The link to the webpage for the preliminary program is: <http://www.sapa.org/SAPAFlyerIIPrelim2.pdf>.

Registrations are coming in on a daily basis.

I try to process and send out receipts on a weekly basis.

The packets did not include a membership form, but the same information is on the registration form. Both can be paid at the same time using the same form.

A request has been sent for approval to the AAPA for 35 hours of category one CME. This approval should be received within the next 4 to 6 weeks. With this approval is received, I will post that information on the conference information page of the website.

Registrations can either be mailed to SAPA Conference Registration, PO Box 623, Monmouth, IL 61462. Or maybe faxed to 309-734-4489. Please fill out as completely as possible.

If you have any questions, please call me on the SAPA registration line at 309-734-5446, and I will return your call as soon as possible.

Thank you and hope to see you in April.  
Bob Potter, PA- C, MPAS, Conference Coordinator



## Society of Physician Assistants in Pediatrics Annual Conference



The Society for Physician Assistants in Pediatrics is hosting their 5th Annual CME Conference in San Antonio, TX **February 18-20, 2011**. The conference is a series of seminars focusing on the continuum of care for infants, children, and adolescents with a variety of common medical problems. The conference is designed to provide lectures and discussion forums on a variety of highly relevant topics ranging from Orthopedics, Vaccines, Obesity, Cardiac Dx in Neonatal Period, Bright Futures, and much more. The invited speaker faculty includes PAs, NPs, and MDs recognized as experts in their medical fields. The meeting has been awarded a maximum of 20.75 hours of AAPA Category I CME with 6.75 additional workshop hours of credit. We encourage attendees that not only practice in general pediatrics or subspecialties to attend, but also those who practice family or emergency medicine in which a large portion of their patient population includes the pediatric age group. For more information please visit the website at [www.spaonline.org](http://www.spaonline.org) or 800-481-0384.

**Society for Physician Assistants in Pediatrics**

is proud to announce the

**5th Annual**  
Society for Physician Assistants  
in Pediatrics (SPAP)  
**Pediatric  
CME Conference**

February 18-20, 2011  
on the Riverwalk at the  
Omni La Mansion del Rio Hotel  
in San Antonio, Texas.

[www.spaonline.org](http://www.spaonline.org)  
Phone: 800-481-0384 or 210-945-8854  
Email: [Monique@planitsat.com](mailto:Monique@planitsat.com)

## Interservice PA School (IPAP) Update

### From COL Pauline Gross, IPAP

Since 1984 the Military PA program, AMEDDC&S has been 24 months long. Prior to that as a certificate program it was 23 months long. In 2004 IPAP transitioned into a Masters degree producing program. The length of the program did not change even though additional subjects were added to meet the Masters Degree requirement. As we all know medicine and what PAs were required to learn has changed dramatically since our inception. More and more information was added to the curriculum to keep the students up to date without adding instructional days.

Several times lengthening the program was brought up to the different services to gain approval by the Interservice Training Review Organization (ITRO). There was always one service that did not approve. Over the years time for physical training was removed from the schedule, patient exams at BAMC deleted, and ACLS was moved to Phase 2. The Accrediting Review Committee (ARC) - PA added new requirements such as a Long Term Care rotation and the OSCE. IPAP began using Blackboard an online program for Phase 2 testing and My Evaluations was added to Phase 2 to replace paper student rotation evaluations. The clinical coordinators requested more time for AHLTA training, JCAHO required classes, and ACLS. Three weeks of leave to PCS between Phase 1 and 2 was decreased to two weeks. Leave during phase 2 was allowed only during Exodus unless it was an emergency. If an emergency occurred students ran the risk of being recycled.

Two students committed suicide and another attempted suicide. The number of students failing the APFT and HT/WT was increasing. Attrition rate was 2.7 times the civilian average and recycle rate was 4.3 times civilian average. The mean national certification examination scores have been decreasing over the past 5 years going from 93<sup>rd</sup> to 70<sup>th</sup> percentile. COL Tozier, program director from July 2007 to August 2010 went to the Dean and CG of the Academy of Health Science, AMEDDC&S for permission to ask for TSG's approval to lengthen the program from 24 to 29 months, 16 months Phase 1 and 13 months Phase 2. He approved the plan June 2009. The plan was forwarded to ITRO at the October meeting and approved by all services April 2010.

The first class under the new schedule Class I-11 began classes on 3 Jan 2011 with MAJ Jeff Oliver as the Faculty Advisor. Instead of three trimesters there are now 4 semesters. Changes were made to all semesters. Four weeks was added to Phase 2 to allow for two weeks of leave and time for hospital orientation. Physical training has been added back on the schedule. All services are doing formal physical training now. This class will graduate April 2012 instead of Dec 2011. Class I-12 in-processes December 2011 with classes beginning January 2012. With their arrival IPAP will have 4 classes in the building at all times for a total of 320 students just in Phase one.

# SAPA Membership News

## Retirements/ETS

The SAPA Leadership would like to thank the following PAs for their service to the US Army and our Nation. They will leave the military in the next several months. Please wish them luck with their new endeavors.

**CPT Veronica Alston**

**CPT Shirley Bauman**

**CPT Diane Boor**

**MAJ Brian Burgemaster**

**MAJ Jeff Clark**

**MAJ John Dana**

**CPT Buddy Davis**

**MAJ Brendon Ewers**

**MAJ Bradley Frey**

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**MAJ Michael K. Garcia**

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**CPT Paul D. Hoffman**

**MAJ Robert Howes**

**MAJ Sue Love**

**CPT Robyn L. Mason**

**MAJ Michael McClendon**

**CPT Vincent Reed**

**MAJ John Slevin**

**MAJ Hollis Smith**

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**CPT Donald Turner**

**MAJ Theodore Wallace**

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**MAJ Tim West**

**MAJ Rick Whitley**

**CPT Stanley Yee**





# SAPA



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Physician Assistant Educational Scholarship Award)

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