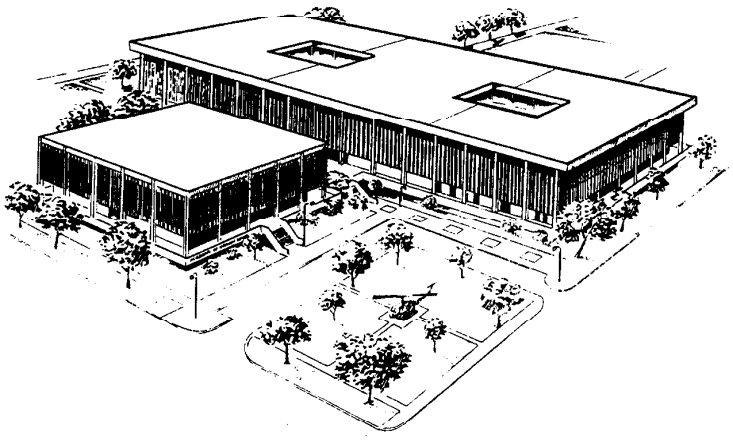
AMEDDC&S OBSERVER

July-September 1999



AHS TO REAFFIRM INSTITUTIONAL ACCREDITATION

During the week of 13-17 Sep 99, the Academy of Health Sciences (AHS) will undergo a week-long site visit by members of an institutional accreditation team from the Council on Occupational Education (COE), a national institutional accrediting agency. The COE is a national agency that accredits military, federal agency, public, private career, and nonprofit training institutions. It currently accredits the AHS, U.S. Army Training and Doctrine Command schools, and the U.S. Navy Bureau of Medicine and Surgery.

Accreditation is the status granted to an educational institution or program that has been found to meet or exceed established levels of educational quality. The process has two fundamental purposes: (1) to assure the quality of the institution or program and (2) to assist in the institution's improvement, if necessary. For educational institutions such as the AHS, accreditation is granted for a period of 1 year with subsequent reaffirmation scheduled every 2 to 6 years. Continued accreditation in the years between COE evaluation visits is determined by the submission of annual reports for approval by the Commission on Occupational Education Institutions, the COE's governing board and decision-making body. The AHS completed an in-depth self-study and site visit and was reaffirmed by the Commission in 1993.

The AHS Accreditation Liaison Officer, Neta Lesjak, indicated that the self-study report provides the AHS staff and faculty an opportunity to assess the overall quality of their instructional programs in accordance with civilian standards. The document is used by course directors to prepare reports required for specific program accreditation. She went on to say that the primary purpose of the visiting team is to determine whether or not the AHS is in compliance with the criteria and standards required for accreditation by the COE.

The six-person evaluation team, headed by Dr. Daniel Dull, Office of the Chief of Naval Education and Training, Pensacola, FL, consists of occupational educators who have acknowledged expertise in specific areas, to include: vocational-technical concepts, educational programs and administration, business and finance, learning resources, student personnel services, and the specialized program areas that relate to the institution's mission.

COMMANDER'S CORNER

MG James B. Peake

As we prepare to enter the new millenium, many of us are uncertain about the possible changes we will face as the Army and the Medical Department postures itself to support our nation and its soldiers. However, the Army, and its Medical Department, historically have always been changing. Change is good – its should be embraced, not feared. As we prepare to enter the 21st century, I would ask you to consider these few examples of change that have occurred in military medicine over the last 100 years and their impact on how we perform our jobs today.

Cardiac surgery was virtually unknown at the time of the Spanish-American War, and heart disease or injury were deemed to be death warrants. Fifty years later, Dr. Dwight Harken, a seasoned veteran of World War II, put his combat surgery expertise to work in devising a new procedure for mitral stenosis. Fitting his finger with a small blade, he treated a valve by dilating it with his finger as well as cutting its calcified ring. Today, BAMC is doing heart transplants; a whole specialty of open heart surgery has developed in less than 50 years. As our medical technology continues to change, surgeons today are exploring the use of laser technology, computer aids, and telementoring to conduct complicated surgical procedures.

Changes not only have occurred in medicine, but in the ancillary services as well. Consider that during the Spanish-American War, the U.S. V Corps landed in Spanish-held Cuba with only three mule-drawn ambulance wagons to support a force of over 17,000 soldiers. During a 10-day period from June 22nd to July 2nd, this force sustained 1,200 casualties. Think about that – three ambulance wagons for 17,000 soldiers. Now compare that with the integrated air and ground evacuation system we have today. The use of helicopters has allowed rapid evacuation of critically injured patients from far forward locations to medical facilities, sometimes in a matter of minutes as opposed to hours.

Change continues today as the Army works to procure the UH-60Q to provide more definitive enroute care during aeromedical evacuation. The Army Medical Department is developing and testing both the Armored Medical Evacuation Vehicle and the Armored Medical Treatment Vehicle to enable future medics to more rapidly evacuate and effectively treat tomorrow's casualties.

As with every conflict, necessity leads to innovation, and the Spanish-American War was no exception. Two notable firsts were the issuing of field dressings to individual soldiers and the first use of X-ray machines to treat combat casualties. Great ideas with the potential for tremendous benefits to the soldier. However, these firsts lost some of their potential due to training and equipment problems. As good an idea as field dressings were for the soldier, there was no first-aid training provided to the soldier. The X-ray was an invention even more critical to patient care. However, the machines were so bulky and fragile that they could only be used in base hospitals or aboard hospital ships anchored off the Cuban coast.

Compare those innovations to the way we do business today. Today, all soldiers receive basic first aid training in Basic Combat Training. The Combat Lifesaver Program was developed to train selected nonmedical soldiers in critical lifesaving skills. Finally, the AMEDD is developing the 91W MOS to better support the Army After Next. This MOS, which combines the 91B and 91C MOSs, will provide EMT-B certified medics where they are needed most – at the front lines where the casualties occur. Our equipment has made

continued on page 3

The AMEDDC&S "Observer" is published by the AMEDD Journal Branch, Department of Academic Support, Academy of Health Sciences. Special distribution is made to all elements of the AMEDDC&S. Additional copies may be obtained by contacting the AMEDD Journal Branch, Room 250, Aabel Hall, 2250 Stanley Road, Fort Sam Houston, TX 78234-6150; DSN 471-6916, FAX 471-8720; Comm 210/221-6916, FAX 210/221-8720. Timely articles of interest are always welcome. Contributions will be edited, if necessary, to meet format and space requirements, and are subject to approval by the "Observer" editorial staff.

Commander's Corner

continued from page 2

dramatic improvements also. That bulky X-ray from the Spanish-American War is now a state-of-the-art, man-portable machine that is available in forward medical units. Let's look at one final example of change. Spanish forces surrendered to the U.S. forces on 12 Aug. By that date, our forces were operationally ineffective due to infectious diseases such as malaria, dysentery, typhoid, cholera, and yellow fever. One estimate was that 75 percent of U.S. forces contracted malaria alone.

Contrast that with the low levels of disease and nonbattle injury experienced by our forces during deployments to both Southwest Asia and Southeast Africa. Why the difference? Today's soldiers practice effective preventative medicine measures and they are immunized against a wide spectrum of diseases, ones which were prevalent at the turn of the century and still are endemic to many regions of the world today. These are just a few of the changes over the last 100 years. What effect did these and other changes have on a casualty's chances for survival? In Cuba, the mortality rate among American wounded was 13 percent; during conflicts between 1965 and 1993 the rate averaged 5 percent. Change is good.

As we enter the 21st century and develop the Army, and AMEDD After Next, change will continue to occur in all areas of medical support: equipment will improve, medical knowledge will continue to expand, doctrine will be re-written, and soldiers will be smarter and more proficient at their jobs. Our challenge is to become an agent of change, not an impediment to it. Adjust to the change, learn from it, and implement it to ensure the mission is accomplished. By doing this we can proudly live up to our charter: To Conserve Fighting Strength.

IMSO CHIEF RETIRES

A distinguished 27-year federal service career came to a close on 11 Jun with the retirement of Louella Buell, Chief, International Military Student Office (IMSO), Academy of Health Sciences.

As director of the IMSO since 1988, Ms. Buell supervised and managed all support services for international military students. During her tenure, she welcomed "at least 2,000 students from 150 countries." She also planned and managed student trips and events that provided a look at local, state, and federal governments as well as local and regional culture and history. Through these programs, the IMSO was able to give students a better understanding of American life and the relationship of the Army to civilian government.

Major General James B. Peake, AMEDDC&S Commander, presented Ms. Buell with the Civilian Meritorious Service Medal. In his remarks, MG Peake indicated that "the International Student Officer Program is very important to the AMEDD Center and School. It is one that we will continue to expand. We participate in many peacekeeping and humanitarian operations with other nations around the world. It is important for us to develop professional relationships with members of medical communities from other nations." Colonel Richard Shipley, Dean of the Academy of Health Sciences, noted the significance of Ms. Buell's contributions to the military community. During a recent trip to Thailand, COL Shipley talked with a young Thai officer who proudly wore the AMEDDC&S badge on his uniform. He went on to say "he thanked me for the professional education he received here, and for the warm welcome and friendliness of the staff while he was a student. Louella Buell has been a superb ambassador."

(information courtesy of Fort Sam Houston News Leader)

A Closer Look. . .

continued from page 4

to greatly reduce the possibility of a test compromise. A videotape will also soon be available as an EFMB training aid. In addition to these upgrade efforts, this section has many other duties. They must travel to all first-time EFMB testing units to validate training and evaluate testing. The office is the proponent for EFMB exception-to-policy requests and the approval authority for rebuttals and appeals from candidates on testing matters. The EFMB Section also collects statistical data from all testing units. This information is a valuable resource to field units because it shows both medical and nonmedical training trends. The data also provides a guide for revising the instructional materials and regulations governing the badge.

The FMT Branch is the AMEDD's focal point for providing challenging training through technology and innovation in all facets of the modern battlefield. Our acquisition of training products, and management of the EFMB Program, further strengthens today's AMEDD soldiers and medical units.

A CLOSER LOOK...

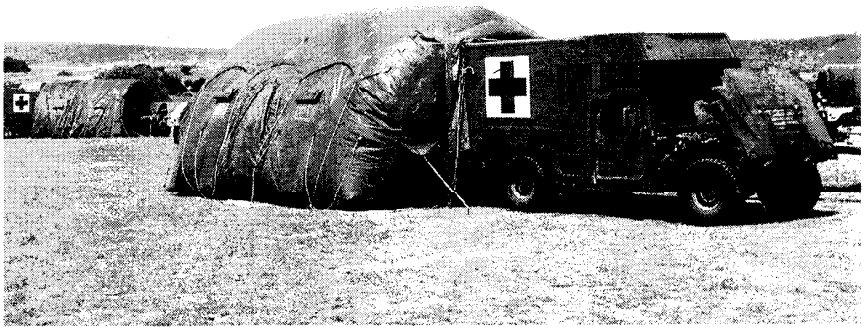
Force Modernization Branch, Department of Training Support

The mission of the Force Modernization Training (FMT) Branch, Department of Training Support (DTS) is to develop training products and strategies for AMEDD and non-AMEDD new systems. The FMT Branch also has the responsibility of being the Combat Developer for AMEDD devices and simulators, the Combat Lifesaver Program, and Manager of the Expert Field Medical Badge Program. Each member of the branch must become involved in the total program management plan. The FMT Branch plays a vital role in ensuring training support is provided for developmental and nondevelopmental systems in a timely and professional manner.

Since its inception in 1982 as the new equipment training branch, it has been the central coordinator for training developer actions involving new equipment and systems at the AMEDDC&S. The FMT Branch regularly interfaces with other DTS branches and individual training developers for all courses within the AMEDDC&S. In addition, FMT coordinates directly with various outside organizations (TRADOC, AMC, MRMC, and DA) on training issues. There are many "players" involved in the acquisition process. The job of coordinating and controlling a collection of tasks, roles, and constituencies requires constant monitoring. The training developer is a very important part of the new equipment acquisition process. Every acquisition of medical material requires training documentation before the items can be fielded.

A Systems Training Plan (STRAP) is developed and staffed Armywide. This document alerts all activities that a new piece of equipment is coming through the pipeline for TOE medical units. The STRAPs support decision-making during the formal and informal in-process reviews. Personnel of the branch interact with the combat developer, AMEDD Test Board, materiel providers, contractors, and subcontractors for each program. As the contractor develops training materials to support the systems, a validation and verification of all manuals, lesson plans, and programs of instruction must be conducted. The coordination of instructor and key personnel training for subject matter experts in preparation for testing of the systems requires timely coordination. A training test support package is assembled and provided to the operational test officer. The FMT Branch has developed training test support packages for the fielding of HMMWV Ambulances, Chemical Biological Protective Shelter System (CBPSS), Deployable Medical Systems (DEPMEDS), Chemical Protective Deployable Medical Systems Hospital, and various other materiel fieldings. Currently, the branch has 30 projects in various states of activity.

In 1997, the 10th Combat Support Hospital was trained as the test unit for the Chemical Protective Deployable Medical Systems Hospital. The 420 personnel assigned to the unit received 20 days of intense training prior to the operational test of the system. This was the largest tasking in recent years for the branch. Following this, the CBPSS (see photo) was ready for a logistics demonstration, a necessary step before testing could be conducted at Fort Hood, TX, in early 1998. The CBPSS is an over-positive pressure system mounted on a heavy HMMWV. The HMMWV provides the total power for the system. Forty operators and 10 maintainers were trained and certified to operate and maintain the system during the operational test.



The EFMB Section, which has the responsibility of administering the coveted EFMB badge, are also members of the FMT Branch. The section personnel, consisting of one officer and two NCOs, are constantly on the road worldwide evaluating training and the actual EFMB testing.

This past year, a major effort was taken to revise the EFMB literature and testing material. Training Circular 8-100, was revised and will soon be published as a Department of the Army Pamphlet. The EFMB Study Guide and the EFMB written tests are also currently being revised. The written test questions are now being loaded into a database that will allow random retrieval of questions. In the future, every EFMB written test will be an original

continued on page 3