

DEPARTMENT OF DEFENSE BLOGGERS ROUNDTABLE WITH U.S. FORCES-IRAQ HEALTH AFFAIRS, IRAQI TRAINING AND ADVISORY MISSION STAFF MEMBERS ADEL HANSON, M.D.; COLONEL BERNARD DEKONING, U.S. ARMY; COLONEL ANDREW KOSMOWSKI, U.S. ARMY SUBJECT: IRAQI MINISTRY OF DEFENSE HEALTH-CARE SYSTEM VIA TELECONFERENCE FROM IRAQ TIME: 9:00 A.M. EST DATE: TUESDAY, FEBRUARY 16, 2010

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LIEUTENANT JENNIFER CRAGG, U.S. NAVY (Office of the Secretary of Defense for Public Affairs): Our guest today is Colonel Andrew Kosmowski. He is with the USF-I Health Affairs, Iraqi Training and Advisory Mission.

Today, the colonel will be discussing the Iraqi medevac teams, which have made great advancements in their procedures to assisting Iraqi medical professionals and making advancements in training and ultimately saving lives in Iraq. Without further ado, I'm going to turn it over to the colonel, to start with the opening statement. We'll go straight to questions. Sir, the floor is yours.

COL. KOSMOWSKI: Well, good evening for me, good morning for you all. Colonel Drew Kosmowski.

I'm an emergency physician, U.S. Army active duty, newly reassigned back here to Iraq in an advisory role and working with Iraq's ministry of defense and specifically with their surgeon general and their minister of defense, in order to try and help them to continue to build capacity within their health-care system, within their defense department.

LT. CRAGG: Thank you, sir.

And also joining us -- Dr. Adel Hanson and then also Colonel DeKoning were supposed to be joining us this morning. So if they do, I'm going to fold them in. Without further ado, let's go ahead first to Dale.

Dale, you were first on the line. Please go ahead with your question.

Q Good morning, Colonel. This is Dale Kissinger from militaryavenue.com. And I'm a retired Air Force guy that flew combat rescue for quite a few tours.

And just kind of interested in why there was such a lowering of the medical capability, from the Iraqis, that was mentioned in the introduction of the blog from Jennifer that there is, you know, significant -- you know, they just don't have much resources or many resources.

Can you tell us why that occurred?

COL. KOSMOWSKI: Well, I mean, the obvious short answer is seven years of war. But the longer answer is that we've -- I mean, through that time, we've kind of taken away a lot of their capacity. And a lot of their -- any of their uniformed military kind of went to ground, when the invasion happened to their military back in '03.

So at that time, you know, their military was not a presence. They didn't maintain, you know, their medevac capability or any of their combat arms capability or any of their support and logistics. Or all those systems all went away.

So once, you know, we began to counter the insurgency that happened, after the armed combat, then it was a process of rebuilding that has taken several years. And we're now getting to the point where we have -- they're utilizing MI-17 helicopters.

It's more of actually a casevac role to -- which the difference is that they don't have Red Crosses or Red Crescents on their helicopters. So they're not dedicated medevac units, as we would say. So they're now developing to the point where they have personnel that are trained in taking care of patients while in flight. And then they're working the aviation piece of it, in order to direct those aircraft, to go to pick up the patient and move them to where they need to go.

So it's been rebuilding but, you know, largely because, you know, we've kind of torn down their military system and in the last several years have been rebuilding it with them.

Q Okay, I understand that. I thought the reference was more to the entire country's medical capability. But you're speaking just to the military capability then.

COL. KOSMOWSKI: Well, sure, it's all of that too. I mean, the -- speaking to like the hospital systems, first of all, there's three systems for health care. They have one for all the public at large under the minister of health or MOH. Then the defense department, MOD, the minister of defense has its own separate health-care system.

And then the national police, and there's different types of police -- border police, oil police, others -- they are working to try and have their own separate system of health care for those personnel as well.

So when you talk about a system, it's really a system of systems, the biggest one being the one for the general public, which is the MOH, which is the most robust.

Now, yes, after -- well actually, probably even before, when Saddam Hussein was here, there was sanctions and other events that happened, that had hindered the health-care delivery capability.

But, and since that time, with the vacuum of no government, there was, you know, a challenge for these -- (audio break) -- to get their supplies and to get their resources; to get quality physicians, to get anybody. And also a huge issue is that a lot of the physicians fled the country.

I want to say more like 90 percent of their physicians, because if they stayed around, they were at risk for being kidnapped for money -- from, you know, the criminal element that is here -- or just being outright killed. So there was kind of a professional drain of the -- of medical capabilities, from this country, that they're now starting to regrow and redevelop.

Q Thank you very much.

LT. CRAGG: Thank you, sir.

Thank you, Dale. Chuck, please go ahead.

Q Yes.

Thank you for taking our call. Chuck Simmins from America's North Shore Journal. I'm a long-time EMT, so the street medicine, you know, has an interest for me.

Do each of the three health systems operate their own ambulances, their own medical evacuation systems? Or for example, the helicopters, do they transport to military, police and civilian hospitals depending on the need?

COL. KOSMOWSKI: Well, that's a good question. They're -- I'll say that they're all trying to. Certainly the MOH, they are capable of -- of working with their ground ambulance systems, and they can move patients from -- you know, when -- if there's a -- you know, a car bombing or other kinds of things, they can go out, grab a patient and bring them to local hospitals. So that is working.

MOD also has ground evac capability, and they have some capability of going out, getting a patient, bringing them back to the military health-care clinics and system there.

The Ministry of Interior is still fairly less developed than the other two, and I don't know specifically if they are having quite those capabilities. They're kind of a little bit behind the power curve as far as getting the training to their medics and to create that capacity.

Now, you talk about Aeromedevac as well. Aeromedevac for Iraq falls under the Iraqi air force, as they're tasked to do all flight operations, including rotary wing. So they don't have an Army Air Corps kind of thing, or Army medevac system. So the Air Force is working -- and again, they're at about a level of a casualty evacuation, or a casevac, where they have non-dedicated aircraft but they put medical crews on those and then they mission them to go and get a patient.

Now, they are -- they have trained flight medics, so didactically trained, capable flight medics that have the know-how, have the schooling to -- of similar flight-medicine training programs that the U.S. uses for Army flight medics to go ahead and do that. They lack the experience, however, to go ahead and do that. So there's an ongoing mentoring mission between our flight medics and the U.S. military and the flight medics in training, if you will.

And additionally, there's mentorship going on at the operational level of the helicopter operations, to bring them to the capacity that they can fly a helicopter with a medical crew on there and be able to pick up a patient. So that's falling under the MOD, Ministry of Defense, responsibilities, for them to be able to develop this capability.

Now, they're coming along. They've had -- every couple weeks, they're having training exercises where they're moving, generally right now, stable patients. And additionally, we're working on an initiative to try and have them on standby for coverage for the elections coming up. (Inaudible) -- confident that the -- this'll be a great capability for them to have been able to at -- to at least participate or contribute to their medical care for the mass -- or mass gathering event coming up. But that's still a work in progress.

Does that answer your question?

Q Yes. Thank you very much.

LT. CRAGG: Thank you, sir.

Thank you, Chuck.

Bruce, please go ahead.

Q Hey, good morning. And good evening to you over there on the other side of the planet. This is Bruce Henderson from New Ledger. I'm curious a little bit about the -- about the training and buildup of these folks. Are -- is it strictly a U.S. Army function? Or are you having involvement from international NGOs as well?

COL. KOSMOWSKI: I'll let you know that I arrived here about three weeks ago, so my knowledge of the full NGO participation is a little limited at this point -- although I am working with the U.S. embassy in trying to learn more as far as what-all is being contributed by our international partners.

The -- that being said, it's not just the Army that is contributing to this training. The Air Force -- there's an Air Force flight surgeon that is -- that is working heavily with the Iraqi air force; and then, again, mentorship within the aviation operations side of it from the Air Force personnel and what we call the ITAM air force, advisory portion. So it's certainly a combined effort with multi-service. And then as far as it being -- or it's actually joint, rather, between Air Force and Army.

But as far as combined: well, in -- not specifically with medevac, but in other aviation initiatives. Like countries like Jordan are contributing to the altitude chamber training required for aviation and other kinds of support to the Iraqi military. Does that answer your question?

Q It does. I had one other, if I could. How many total aircraft and crew are -- Iraqi aircraft and crew are participating in it at this time?

COL. KOSMOWSKI: The -- I can speak to the MI-17s. That's the Russian kind of mid- to small-size helicopter. There are -- I only know because we've been looking into having them on standby, but I'm told that there are six of them that are flight-worthy and that implies that there are others that are maybe in various stages of maintenance. But that -- and that's just for that airframe. And that's the one that currently we're doing most of the medevac missions with.

The Iraqi air force also has a number of Hueys, and I don't know what that number is. And then there's -- yeah, I think that's it for rotary wing. I do not know -- it's not my field of expertise to know how many of each different types of aircraft they have.

Q That's fine; I was curious more about the crews, how many --

COL. KOSMOWSKI: Oh, crews, right. I'm sorry. There -- I think there's enough for probably about four flight crews, and the -- they'll put a couple of flight medics on board. And again, there's generally, right now, mentorship involved with a U.S. either flight surgeon or flight medics, supporting their training and missions.

Q Thank you very much.

COL. KOSMOWSKI: Sure, sir.

LT. CRAGG: Thank you.

And Jarred also sent in some questions. He's on the line, but he asked me -- it's hard to hear him, so he asked me to ask them for him. So here goes. Could you discuss the recent progress that you have seen in the previous few months regarding the amount of personnel being brought into the program? And how are the training schools being established for future, once U.S. support begins to wane?

COL. KOSMOWSKI: Okay. I can speak to some of that. And I'll remind the audience that I've been here for three weeks, and not three months.

But in -- what I've learned, the numbers have been -- of crews -- I really -- I don't know how many personnel have been trained through this program. It -- but I do know that there's been a fairly long training period for this, including initially a didactic portion where these students went through a -- the similar kind of flight medic training that our soldiers would get, like at Fort Rucker with the flight-medical training there.

And the flight medicine course, along with many of their other medic-level training, is conducted at a training wing in a -- kind of in a schoolhouse that's in -- they call it the -- in the city of Taji. It's -- there's a -- it's called the medical training wing, but it's kind of the wing of a building, and it's a -- it's functioning, but it's temporarily their solution at this time.

Now, what they're building -- it should be open -- the latest estimate was October -- is kind of their version of a small-scale Army medical department, center and school, our -- like what we have down in San Antonio, Texas. And this would be like their health services academy for the medical -- I'm sorry, the Ministry of Defense. And that is adjacent to their medical city, which is kind of their civilian community of hospitals within downtown Baghdad here. And it is a former British post and Iraqi military post that will now become the -- it's being rebuilt to contain classrooms that would be connected to -- back to the Army Medical Department Center and School in Texas in a partnership/mentorship program.

But again, this is still under construction, and the IT portion of it to connect the -- you know, the electronics and the classroom brainpower back to the U.S. military teaching resources, that's still in the works. But that's the plan, and that's where they're going.

But in the meantime, I mean, they have a very robust training program with -- they're doing basic medic and doing medical logistics training.

They're doing advanced medic training, flight medic training through this training wing. And they're also doing train the trainer-type training, so -- (chuckles) -- too many trains here -- but they're -- so in essence they're training themselves in these medic courses.

So we're -- you know, you could use the old -- the old expression that "they're teaching themselves how to fish now," and we're less involved with that, which is a good thing, (which ?) they need to be. And they are; they're taking over their -- you know, their future creation of this. So in so far as -- you know, it's not productivity of how much the U.S. are training medics anymore, it's that we've created for them and worked with them for their capacity to now train what they need for the future.

LT. CRAGG: Thank you for answering that. I -- I've been receiving a couple e-mails from Dr. Hanson and Colonel DeKoning. Apparently they're trying to call in. So what I'm going to do is, I'm going to try to conference Colonel DeKoning in. I'm trying to determine if they're both together on the same line. So what I'm going to do is just go around the horn again and have Dale answer the call -- I mean, not answer the call, ask his question. And I'll see if I can fold both the other doctors in. Is that okay with everyone?

Q Sure.

COL. KOSMOWSKI: Absolutely.

Q Works for me.

Q Yeah.

Q Sounds great.

LT. CRAGG: Okay. Keep on going in. I'm going to go ahead and call him.

Dale, please go ahead.

Q Okay. Doctor, how many people are in their training program?

COL. KOSMOWSKI: I'm sorry, I don't have that number in front of me. I mean, it's -- in general the -- you know, the Iraqi military is rebuilding and regrowing. And they've -- you know, they've planned for, like, 17 divisions, and so they're trying to fill them up, you know, in a kind of an even manner. But -- so the -- you know, the complete percentage of fill for all the divisions is fairly low, but I mean, exactly how many medics they have, you know, how many -- and I don't know, you know, how many they have in the classes going right now.

DR. HANSON: Hello?

LT. CRAGG: Yes, hello. I'm sorry, let me interrupt you. This is Lieutenant Jennifer Cragg. Dr. Hanson can you hear me?

DR. HANSON: Oh, hi. Yes.

LT. CRAGG: Okay, I'm sorry, sir. I have Dr. Hanson and Colonel DeKoning on the line. I was able to conference them in.

Dr. Hanson and Colonel DeKoning, right now Colonel Kosmowski is answering a question by Dale, and then we'll fold you in.

I'm sorry, sir. Colonel Kosmowski, please go ahead.

COL. KOSMOWSKI: Okay. I don't know, maybe Colonel DeKoning --

DR. HANSON (?): Hi -- (word inaudible).

COL. KOSMOWSKI: -- hello -- maybe Colonel DeKoning could answer the question better if he has better visibility on how many students are currently attending the medical training wing in Taji. I don't have visibility on that number.

DR. HANSON: Okay, just a second. Colonel DeKoning is on the phone. Sorry.

They are on the line, sir. Colonel Kosmowski --

COL. DEKONING: (Off mike.) Did you get through?

DR. HANSON: Yeah, but it's on the -- on the speaker.

COL. KOSMOWSKI: Well, I'm sorry. I don't -- I don't have that information for you, sir.

COL. DEKONING: Hang on. I think we got through.

DR. HANSON: Can you hear?

COL. DEKONING: On another -- (off mike).

LT. CRAGG: Just one second, Dale. (Pause.)

Colonel DeKoning? DR. HANSON: (Inaudible.)

COL. DEKONING: We finally got through.

LT. CRAGG: Yes, yes, thank you.

COL. DEKONING: A half hour of trying.

LT. CRAGG: Thank you for your patience. Dale Kissinger is going to re-ask a question that he asked Colonel Kosmowski.

Dale, please go ahead. (Pause.) Dale? Dale, are you still on the line?

DR. HANSON: He asked about the number of the -- (off mike).

LT. CRAGG: Chuck, Bruce, Jarred, is everyone still on the line?

Q I'm still here.

LT. CRAGG: Okay.

Q I'm still here.

Colonel DeKoning, I can maybe re-ask the question.

LT. CRAGG: Okay.

Q The question was about the number of current participants in the Taji medical training wing. Do you have visibility and know about how many medics in training are attending training in Taji at this time?

COL. DEKONING: Taji, in each training cycle, usually trains about 60 medics per cycle. And so I'm not sure they have a -- currently have a training session ongoing right now, but they usually train about 60 per cycle.

Q And how long do the cycles go?

COL. DEKONING: They go six weeks.

Q I hope that kind of (directs up ?) the question.

LT. CRAGG: Okay.

Dale, did you just rejoin us?

Q Did -- for some reason I dropped off.

LT. CRAGG: Okay. That's okay. What we did is, we re-asked your question, so it will be in the transcript, so we'll make sure -- it was at the zero-nine-twenty-two mark, zero-nine-twenty-one mark. And it will be in the transcript as well. Colonel DeKoning had answered your question.

But Chuck, please go ahead with any follow-on questions.

Q Thank you. Chuck Simmins from America's North Shore Journal. The capacity that the Iraqis are developing now, could someone speak to how it compares to what existed prior to the events of 2003, and you know, give us some idea of where there have been improvements?

COL. KOSMOWSKI: Yeah, I can try and answer that for you. It's Drew Kosmowski. I -- okay, as of -- I was here in 2003 as part of the initial wave. I was an emergency physician for a combat-support hospital during that first year of '03. And what capabilities we were -- we were told of, as we were preparing to come through here, was that there was -- they had medical units within their divisions. They had kind of field-medicine capabilities. They had medical-supply systems. And then, their health-care system for the civilians was -- let's just say it existed, in fact, but it kind of mattered on which hospital and who that hospital served as to whether or not there was quality of care or just kind of "you get what you get."

For example, when I was in Tikrit for much of the year, initially the Tikrit teaching hospital even had the capability of CAT scan and ultrasound that we were able to use for U.S. soldiers when they needed those, and not for trauma patients, but for like more routine things. But then with the insurgency and the security getting worse, we could no longer use that.

I've also learned that over time -- and actually, the insurgency did a lot to undermine the health-care infrastructure, because you know -- as there was no supplies moving around, as nobody was employed because there was no government. Then, you know, even these teaching hospitals that had some capability and had some, you know, personnel, you know, capable radiologists, for example, you know, they would -- they would kind of fall into disrepair over the time because of the insurgency since 2003.

So to summarize, I guess they had a kind of have-and-have-not system beforehand. They had a decent medical system within the military. The insurgency had undermined that to the point where, now with the government reestablished, they're likewise reestablishing the medical system over the last few years. Does that answer your question?

LT. CRAGG: I know that's a little hard to hear. Luckily we'll have a transcript from the call. Thank you so much, sir. Colonel --

COL. DEKONING: I can add -- let me just add one other thing to what Colonel Kosmowski stated. A number of physicians left in 2003, 2004, when the security situation really started deteriorating. And over the last I would say 10, 11 months, we have seen a number of those physicians return, and most of them are going into the ministry of health. And some of them are also going into the ministry of defense. And so this is a good sign. It's a good thing. And it shows that people have not lost faith in the country. And everybody you speak to, at least within the Iraqi security forces, is saying that -- or is supporting the statement that physicians are indeed coming back.

Now, these are physicians that had left to go to -- usually just neighboring countries, usually to Jordan, or in some cases to the U.K., and those are ones that are coming back. So this is a good thing, and this is a sign that things are gradually getting better.

LT. CRAGG: Thank you, sir.

Dr. Hanson, did you want to add anything?

DR. HANSON: Yeah, just a quick comment on what Colonel Kosmowski was saying that I heard from -- (inaudible) -- that the targeting for -- not only for the physicians but for any medical professionals -- as a matter of fact, they have a -- (inaudible) -- checkpoint and they find a lab coat in the car, they immediately assassinated the owner of the car or anybody in the car.

If they walk between buildings and they have a lab coat or some medical equipment, they've been assassinated that way. So, many of them, like two colonel was saying, they escaped the country because of that reason; they were targeting the physician and medical professional in big way.

Thank you.

LT. CRAGG: Thank you, gentlemen. I know that Dale, Chuck, we went around the horn, but Bruce, do you have any follow-on questions?

Q Actually, I did. Retention of personnel once they're trained, medical professional types, or they have even basic field medicine skills, how do you keep them in the army, or is it not nearly as flexible as it is in the United States?

DR. KOSMOWSKI: It's very difficult. I'll answer that from the MOD side of things, and maybe Colonel DeKoning could answer from the Ministry of Interior or the police side of it, as we kind of discussed earlier the separation there. But the surgeon general is briefed on a bi-weekly basis on numbers of kind of recruits or folks into -- or physicians into the health-care system, but also those that leave. So, you know, there is -- you know, there is a flux of physicians coming into the MOD but also those that are leaving.

And it's a challenge because on the one hand, the MOH pays the best, they have a higher salary, and these folks, they -- (audio break) -- the cities, they can live where they want to live, and, you know, they get more pay to go there. If you want to be a doctor in the army or air force, well, you have the chance of deploying, you have the chance of being targeted by criminal elements because you are supporting the government, and you have the lower pay. And so there's a lot of challenges that are against, really, keeping good providers in the MOD health systems.

Colonel DeKoning, do you have any comments from the MOI side?

COL. DEKONING: Yeah. Thanks, Dr. Kosmowski.

The MOI side is also a challenge, just like the MOD side is. I would say a little bit more so because their pay disparity is larger than with the Ministry of Health, and the fact that in the Ministry of Interior, the organization is different, the culture is different, and it makes retention and recruiting that much more difficult. Now, I am seeing some positive signals, though, from the Ministry of Interior that they are trying to turn that around. And part of that is through increased collaboration with the Ministry of Defense and to keep up the momentum of the collaboration that they have with the Ministry of Health.

So it's going to take some time to turn this around with the Ministry of Interior, but eventually they will catch up. It's just going to take time.

Dr. Adel, have you got anything to add?

DR. HANSON: No. I think that's the case.

LT. CRAGG: Okay. I'm sorry, sir. I know that we're coming close to the wrap-up of the roundtable. And I know both Dr. Hanson and Colonel DeKoning joined us a little bit later. Is there any follow-on thoughts, any follow-on questions before we wrap up today's roundtable? (Pause.) Dale, Chuck, Bruce, Jarred?

Q It was very informative, thanks.

LT. CRAGG: Great.

I'd like to turn the floor back over to Colonel DeKoning, Dr. Hanson and Colonel Kosmowski if -- gentlemen, if you'd like to end with some closing thoughts today.

COL. KOSMOWSKI: I will, sure. What I am seeing is that, you know, we don't need to kind of, you know, pity the health-care system here. I think that they are at a very exciting time in the crossroads of Iraq. They're rebuilding their medical systems at a time of modern medicine. And with cooperation and with -- you know, with some initial guidance and support from the international partners, they actually are well-poised to develop a really -- into a very world-class medical system in general. I mean, you know, they've been beaten down but they're building back, and they can build back stronger, just like other nations have in the aftermath of war.

So, you know, it's a very hopeful time, and I think that we should, you know, continue to support them to go their path. But I think they've got a great future.

COL. DEKONING: Yeah, I agree. This is Dr. DeKoning. I agree with Dr. Kosmowski wholeheartedly. Iraq at one time was the envy of this region in terms of their health-care system. And as Colonel Kosmowski stated, they are poised to regain that stature and then to even exceed that. If you consider that over the last 35 years the entire medical community of the country of Iraq was essentially locked in a closet, they are now coming out of the closet, so to speak, and are interacting with the outside world. And because of that, this is rapidly gaining momentum. And I am very, very -- very hopeful, very confident that eventually Iraq will regain that stature if we continue on the trend that we are. And I have no reason to doubt that Iraq will become again the envy of this region.

Dr. Adel, do you have --

DR. HANSON: Yeah. I think my hopes as I came to Iraq is really --(inaudible). I think the American forces here treat the -- because of the global health care, so we treat the Iraqi as we treat the -- same health care United States. And by helping with preventing the diseases, take care of those with bacteria that become resistant to many antibiotics, so at the end it will help the global health care by helping the Iraqi. And I see the Iraqi physician are eager to learn and eager to enter the new era of medicine.

Thank you.

LT. CRAGG: Thank you, gentlemen. Thank you for all your closing statements. And thank you to the bloggers who called in. I'm glad that we could fold everyone in today.

Just an administrative note. You can access a transcript from today's call if you visit [www.dodlive.mil](http://www.dodlive.mil). There you'll find a transcript as well as the audio file and a story from today's roundtable.

Thank you, everyone. Thank you, gentlemen, for calling in. And this concludes today's roundtable.

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