

DEPARTMENT OF DEFENSE BLOGGERS ROUNDTABLE WITH COLONEL JOHN POWELL, DIRECTOR OF HEALTH AFFAIRS, MULTINATIONAL SECURITY TRANSITION COMMAND IRAQ VIA TELECONFERENCE FROM IRAQ TIME: 10:32 A.M. EDT DATE: TUESDAY, AUGUST 26, 2008

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LIEUTENANT JENNIFER CRAGG (Office of the Secretary of Defense for Public Affairs): Hello. Hi. This is Lieutenant Cragg. Is Colonel Powell there?

COL. POWELL: I am, ma'am.

LT. CRAGG: Okay, perfect. We have Chuck Simmins on the line, sir. We're waiting for a couple more bloggers, but we're going to go ahead and get started, and more than likely they're going to be calling in as you start into your intro.

COL. POWELL: Okay.

LT. CRAGG: So with that, I don't want to waste your time, so I want to go ahead and get started with this. So with that, I'd like to say hello and I'd like to welcome you all to the Department of Defense's Bloggers Roundtable for Wednesday, August 26 -- excuse me, for Tuesday, August 26, 2008. And good morning.

Who's joining us?

Q This is Grim, from blackfive.

LT. CRAGG: Okay, Grim. And my name is Lieutenant Jennifer Cragg. I'm with the Office of the Secretary of Defense for Public Affairs. And I'll be moderating the call today.

Today our guest is Colonel John Powell. He's the director of Health Affairs for Multinational Security Transition Command Iraq. Colonel Powell will discuss a myriad of topics, to include his experiences working with Iraqi counterparts on improving medical capacity and building capabilities of the Iraqi security forces.

And before I turn it over to you, sir, who joined us after Grim?

Q Jared -- (last name inaudible).

LT. CRAGG: Okay, roger that. Okay, Chuck, you'll be one, Grim, two, and Jared, three. With that, sir, welcome aboard and I'll turn it over to you.

COL. POWELL: Okay. Just by way of introduction, my name is John Powell. I think you've got my obituary -- excuse me, my bio. And that tells where I've been. I guess it doesn't explain much about what we're doing here.

But we have a staff here of about 12 folks spread throughout the pieces. I have an expert on medical architecture assisting with building facilities for the Iraqis -- actually, mostly small but nonetheless important to them -- in various different places throughout the country. We've got two logistics personnel here and three logistics personnel up at Taji, which is northwest of Baghdad, where we do -- where we assist with the Class VIII, our medical materiel supplies that are used throughout the Iraqi army and navy and air force on the ground.

We also have medical planners or medical operations personnel who do planning and establishment of systems for the Iraqis and their director of military medical affairs, run by Surgeon General -- Brigadier (General) Samir. Then a couple of providers -- two physicians assistants, one from the Army and one from the Air Force, mostly for training, setting up various different courses and assistance with extended learning pieces and parts for the Iraqi military medical system. We also do some work with the Ministry of the Interior, most directly with the National Police folks and how they are supporting their personnel in various different places throughout the country, actually multiple places. They have clinics in seven different locations. And their National Police personnel are spread really throughout the country. And actually, the National Police force in and of itself is not all that huge. It has about 40,000 members. But totally, the Ministry of the Interior has more personnel than the Iraqi army does, somewhere in the neighborhood of 300,000 folks, so a lot of folks that need support and that we're trying to build an infrastructure for.

A typical day here is a fair amount of time spent over at the Ministry of Defense, surgeon general's office, Brigadier General Samir with the folks that he has.

I was on the ground here exactly five years ago. I actually got here in April of 2003 to Baghdad when the major hospital that we used for coalition forces as well as life, limb and eyesight care for Iraqi military was kind of a hull and a husk of what it is now. Windows were all broken out, a lot of dirt on the floor; it had pretty well been cleaned out and looted of all the necessary pieces and parts to include wiring and light fixtures, everything. It's now an up-and-coming hospital. I'm sure some of you have seen the "Baghdad ER" episode which was shot from the emergency area at Ibn Sina Hospital.

So I think that probably covers what I wanted to introduce with. I'll be glad to try to answer some questions for you. And we'll go from there.

LT. CRAGG: Thank you, sir, for that explanation. I appreciate it.

We're going to go ahead with Chuck, and then after that is Grim. So please go ahead, Chuck.

Q Good morning, Colonel. Chuck Simmins from America's North Shore Journal. Greetings from the warm and sunny shores of Lake Ontario.

COL. POWELL: Ah. Well, it's very warm here and it's also very sunny, but little different, I would suspect.

Q Yeah.

COL. POWELL: Which part of the shore?

Q Rochester.

COL. POWELL: Ah, okay. Well, I'm from Ogdensburg, so I know where that is pretty well, actually.

Q I wanted to ask about the overall structure of both the police -- (audio break) -- COL. POWELL: (Audio break) -- General Samir says he has plans down the road, and I believe him. He's set up some long-range planning and capabilities studies to have it in position so they can, in fact, treat family members and take care of them at least for simple things like immunization and preventative medicine pieces. But as it stands now, they do not treat family members, only active duty.

And because of their shortages, they depend pretty heavily on the Ministry of Health, which is obviously an entirely -- or not obviously, necessarily, an entirely different organization. So they can refer folks from the military medical system into the Ministry of Health for other kinds of care that aren't available.

Q And the police -- the National Police, is that operated the same way?

COL. POWELL: Yes. And actually, the national police is staffed, from the medical standpoint, actually at a lesser level now than the Ministry of Defense is. So you can guess that that makes it even tighter as far as their care goes.

The Ministry of Interior and the national police have standing agreements with the Ministry of Health to support them for routine care and also for anything that needs to be referred.

For instance, during Operation Knight's Assault, which was done in Basra not too long ago, a few months ago now, the Ministry of the Interior and the national police force sustained some casualties. And some of those casualties they evacuated back here to Baghdad from Basra on Ministry of Defense/Army C-130s. And when they got them back here to Baghdad, they took them to various different hospitals because the MOI does not have a big -- what we would extended level III health care facility. So they use the Ministry of Health facilities as well as some assistance from the MOD to take care of those folks. So they're actually in a -- they're tighter as far as their overall care capabilities go than the Ministry of Defense.

Q All right. Thank you.

LT. CRAGG: Okay. Grim?

Q Yes, sir. I would actually just like to get you to continue to elaborate a bit on the partnership and the way in which these bureaucracies are working together and, you know, the degree to which it's working well, working

badly. Just tell us a bit more about that, because that's a very important overall concept for the governance of Iraq.

COL. POWELL: Sure. I think that, from my perspective, anyway, the issue with working with the Ministry of Defense -- when I was here first -- and I did meet General Samir when I was here five years ago, and he had almost no capabilities. There was himself and an office assistant, a secretary, if you will.

They have over the course of the last five years built a fairly substantial -- but not to our degree -- capabilities group and staff. They have about 70 folks in the office. They have a director for logistics, a director for training and a director for long-term teaching and capabilities. One of the issues that we've had over the course of the last few years is, they have built slowly and surely what we would call kind of level II clinics. They have some capabilities to admit patients and take care of them. And over the course of time, they've garnered a fair amount of medical equipment that -- you know, EKG machines and sonograms and X-ray capabilities and those kinds of scenarios.

Over the course of the last three years, we have done a fair amount of support as far as taking care of those, of that equipment.

And we have -- we're transitioning that to strictly an Iraqi capability. My last job was as commander of an Army medical center, and I can tell you from previous experience that medical maintenance is a tough job. It's very difficult to do. It's very costly. You can only have so many people doing the job in the space that you have allocated and allotted. So you have to be -- it's very fund-intensive and very labor-intensive, and if you don't have a group of folks who understand repair, then you have to rebuild that system.

The Iraqis have none. They have no intrinsic medical maintenance capability. And we've been working -- that's one of the things -- one of the issues they've been working hard, and truthfully butting their heads a little bit, because they understand it needs to be done, they understand it's an important piece of it, but they also understand they don't have any capabilities, and they haven't grown any capabilities. So at the same time as us helping them get a maintenance contract together, so that they can take care of the equipment they have; also building a long-term training capability, so they can make their own medical maintenance technicians over the course of time, and teach them to do the things that are necessary to maintain medical equipment.

That's just a kind of a for-instance as far as one of the issues that we're working pretty heavily with them.

One of the other issues is, as you gathered from my statement, if they have -- they've got assigned capabilities for 800 physicians, and they only have 160, there's a lot of recruitment and retainment issues there. There are a fair amount -- there have been some stories written not too long ago, fairly recently, actually, about retention, about going outside of the -- outside of Iraq, of the borders of Iraq, and enticing some expatriates to come back here, to go back to work.

In the past there have been some significant issues with security. Those are much better. They're not perfect, obviously, but they're much better. And truthfully, right now, it's a matter of "Can you pay what I can make someplace else?" And probably the answer is no. But that said, there's a lot

of these people who want to come home. So we're working with General Samir and with the Ministry of Defense. And they have a pending law. It's a two-piece -- actually, it's more than two pieces, but from my perspective as a doc, the two pieces are veterans' affairs and veterans' care, and long-term remedial capabilities for veterans. And it also has a piece about pay and special incentives for physicians for recruitment and retention. Q Thank you very much.

LT. CRAGG: And just to make sure, did anybody else join the call when Colonel Powell was speaking? (Pause.) Okay.

Sorry, sir. I just wanted to make sure we got everybody.

COL. POWELL: No, that's okay. Grim, did that help point some direction for you?

Q Yes, thank you.

LT. CRAGG: And Grim, we'll go back after we get Jarred's questions. Then I'll start with Chuck, and then, Grim, you can go round for round two, if that's okay.

So, Jarred.

Q Yes.

Sir, thank you for your time. Could you talk a little bit about the training courses which are set up, in other words, from the time -- from five years ago until now versus five years from now, into the future, building the capacity of the Iraqis as opposed to simply bringing the doctors back from abroad but also building the indigenous population within the country? How is that going?

COL. POWELL: Sure.

The -- actually one of the things that I as a physician find the most interesting here is that they have a very capable medical school in Baghdad. And they teach and train physicians on a regular basis but they do it in English.

I personally had enough difficulty with going to medical school, when English is my first language. But these are all Arabic-speaking people and they're going to medical school, and everything is being taught in English. And having talked to some of them as they're working their way through it, I find it kind of interesting how difficult they have, as far as getting through school goes and learning everything and trying to put it back and forth into Arabic.

So that's one of the issues, but they are growing their own physicians. And they're good physicians. We also have helped them with a trauma training program at Ibn Sina Hospital. Until the last few months, we taught the program.

We had physicians and we had nursing teachers and instructors that taught all of the information, all of the materials, all of the syllabus that was given and that was directed. We did it. Over the course of the last three to four months, they have transitioned. So now they're teaching the course themselves.

I think the thing I would closely align it with is advanced trauma life support. That's a course that we teach in the States and that actually is taught all over the world. That's the basic Airway, Breathing and Circulation kind of trauma scenarios for physicians, many physicians. It's a refresher. You go every four years.

I'm a certified instructor. I've been teaching a long time and I've sat in on their course here. It's probably not quite to the degree that, we would say, we would teach ATLS. But it is significant and it does do a good job, of refreshing some of the folks who don't have much background and teaching some of the new guys who haven't seen a lot of trauma.

That's one of the courses. They also -- we also help them teach up at Taji. I talked about that before, which is -- Taji is the national depot for classes of supply and for logistics for the Iraqi army. And we also have a training center there.

One of the pieces of the training center is called Phoenix. In the Phoenix, we teach the maintenance and the teams, the training teams that we send countrywide to assist the Iraqi army with very different issues. And one of those is medical.

So when we have a group come in that goes out as a training team, they come to Phoenix -- they go to Phoenix at Taji, and we teach them specifics about how to get combat lifesaver trainer out to the pieces -- out to their individual units.

We've also worked hard with the NATO Training Mission guys here to set up various different kinds of courses, advanced cardiac life support, advanced trauma life support, pediatric advanced life support, advanced burn life support, stuff that in the United States and European Union and Canada and lots of other places we teach as a matter of course. It's not -- in the past, those kinds of courses were available in Iraq. They haven't been, but it's one of the things that other countries outside have said we want to help. This is a way we can help without putting forces on the ground, but we can, you know, get more information out, and we can help build a better medical system here within Iraq.

As far as basic medic goes, medics -- like I said, the combat lifesaver course, we helped them teach our trauma -- our training teams, our MiTT teams, or military training teams, helped them with that information. We have certified instructors who are teaching combat lifesaver every single day to the jundi or to the basic soldier on the ground in the Iraqi army, as well as the -- they have a small air force and small navy, but they're also getting the same kind of instruction.

The courses are courses we have that we've taught for a long time, and the idea is to transition and what we call train the trainer kinds of courses. They're getting there. It's significantly better than it was before. And the information that's passed is good information, and they're learning it. I spent last week out west, and the 7th Iraqi Division is there. And talking with some of the soldiers and watching them go through their common training tests, they're getting it. They're getting it.

LT. CRAGG: Okay. Chuck or Grim, do you have any questions for Colonel Powell?

Q I do. Colonel, could you talk about -- you talked about the doctors. Talk about nurses, phlebotomists, all of the other -- the skill sets that are needed to support a doctor, and how that's going.

COL. POWELL: Sure. Q And then, could you also talk about the basic level of health care provided the ordinary grunt? I know when we go into the service, you know, we get all those shots. We get a good physical exam. You know, the -- what does the jundi get when he signs up?

COL. POWELL: Okay. As far as the numbers and the potential for (fill ?) -- I think I talked about the physicians piece of it. We have over 800 potentials and about 160 positions filled.

As far as the medics are concerned, they have available positions -- and I'm reading off a chart I have here -- about 3,000 authorizations and capabilities. They have just about half of that, about 1,500 of those filled. As far as nurses are concerned --

Q Is that combat medics?

COL. POWELL: Yes. Yup.

As far as other authorizations, they have authorizations for about 300 nurses, and they have between 90 and 100 -- I'm sorry; the last number I have is from May, so -- I know that's higher, but I don't know how much. It's actually -- it's probably about a third is probably a safe guess of what they really have. And then they have -- they list about 6,000 other positions in the medical field. That's administrators -- like you said, phlebotomists -- that's planners, that's orderlies, ambulance drivers; it's the whole gamut. And they have about 40 percent of those. So they have around 2,000 or so. So the other levels of capability are probably a little better than the numbers of physicians that they have, but not extensively so. So that's concerning as well.

They don't -- the Iraqi medical system in the past has not used what we would call physician extenders, nurse practitioners, physician's assistants. That's another issue that we've talked about -- General Samir talked to -- with him about, so that other folks have more capability, and if you don't have a physician, can you fill -- can you do a better job of taking care of folks with physician extenders, nurse practitioners, PAs, et cetera. And I think that that's fallen on -- that's fruitful discussions, and I think that he understands that piece of it, and if we had them, he'd be glad to use them in the positions they have.

The second piece to your question, as far as the jundi is concerned, everyone gets an entrance physical. That's part of it I've seen actually hands-on. They get a certain number of immunizations. I can't honestly tell you exactly which ones. I can tell you that not everyone is getting them, because we see occasional cases of tetanus, which, you know, in our medical society, is scarcer than hen's teeth. So it does in fact happen that they don't get some of the basic stuff that they need. One of the things that's important for us to teach and that we're doing -- we're working hard at -- with the far-flung divisions, 7th Division out in the west sector, for one -- one of the specific things that they get -- that our guys -- the training that the MTTs get taught is basic preventive medicine, water monitoring and sanitation and the basics of preventive medicine. That truthfully in the past has not been a big deal here. It is a big deal for them now. They very much understand that if they can slow down some of the pieces and parts to begin with -- in other words, a diarrheal

disease, which is a real big deal here, and there every year is a few -- a handful of cases of cholera and typhoid simply because they don't have extensive clean water every place. And if they're -- they want to be sure that they're doing okay and right by the thing, they drink bottled water. So that's a big issue.

As far as the rest of what the basic medical supply piece is, it's tough for me to tell you. I don't honestly know in most cases how much they get, but I know they do get some -- here in Baghdad, anyway, they do get some basic immunizations, and they get a recruitment physical. They get a basic evaluation to begin with, to be sure that they don't tuberculosis or some communicable disease that they obviously would spread someplace else.

Q Now how does their physical compare to what an American soldier would -- or recruit would get?

COL. POWELL: It's not as extensive. You've been in the military before. You remember a lot of people were done at the MEPS station. But they do -- some medical professional looks at every single one of them to evaluate them for the basics. If there's some question, they do have lab capabilities, they do have X-ray capabilities, and they use them if they need them. But they make the decision -- and I made this comment to someone else the other day, and they were a little bit taken aback.

But their physicians are good diagnosticians, maybe better than some of ours, because they don't have the backup. It's not -- if someone comes to an emergency room in the United States of America and I'm working there, if there's some question, they get a CT scan. There aren't that many -- that extensive capability here. You have to make a decision about what you think is wrong with somebody and go from there without huge amount of backup.

Someday -- in the United States, if we have an issue, military or civilian, and there's a question about somebody's back pain and they have sciatica, they get an MRI. There aren't extensive MRI capabilities in Iraq. So you have to decide what you think is going on and treat it as such.

So for evaluations from diagnostics, their physicians are pretty good.

Q Okay, thank you.

COL. POWELL: Sure.

LT. CRAGG: Okay, and Grim or Jarred, we have time for maybe at least one more question.

Q I have a question. This is Grim, with blackfive. This -- and if this is out of your lane at all, Colonel, just say so, because I don't want to take you out of what you're comfortable talking about. But I know when I was over there, we did a certain number of med-ops where we went out to rural areas like Khidr that hadn't had medical care and the military provided medical care. And I was wondering if the Iraqi army is interested in developing that capability for areas that are sort of far-flung or if that's something that they're hoping from the ground going the Ministry of Health will be able to take over.

COL. POWELL: You know, that's a good question. And I'm not blowing smoke up your backside, because it's a question we've asked a lot.

And having -- you've been involved with what we used to call MEDCAPs or (Med-Readys ?) before in various different places. It's one thing to go in and treat somebody and make whatever they have go away. You know, it's simple to spread antibiotics. Some of the basic preventative medicine stuff that we can do at the far-flung places are the things that really need to be done. If you can immunize a kid for tetanus, then you won't have to follow up with something else later.

So basic preventative medicine stuff, they have -- they understand the need for it. They understand that particulars. It's a matter of assets. And the numbers of physicians -- I made the comment to start with about 160 out of 800. Those physicians, by and large, are grouped in the big cities, in Baghdad, in Basra, in Mosul, in Kirkuk, in Kirkush, in Tikrit. They flock to those places because they can -- their families can live there. The security is better and there are less issues.

So you make a good point. Out in the hinterlands is where we've got the biggest issues and where we have the -- I would think -- I know that General Samir has got some significant direction in those places.

And they do work hard with the clinics they have, even though they're understaffed, at doing the preventive medicine stuff, to try to get things headed in the direction they need.

And they understand that they could extend things a lot if they had certain power, 24 hours a day without question, and they had certain clean water, and there were no issues with it, and it could be drunk from the tap. And that's not the case right now.

Q Fair enough. Thanks.

COL. POWELL: You bet.

LT. CRAGG: Okay.

Jarred, time for one more.

Q Yes, sir. What about the sectarian influences -- like you said, you go with the 7th Division out in the West -- between the Sunni, the Shi'a, the Kurd, the ministry of the interior, defense? What's the status on the ground that you're seeing in the last few weeks?

COL. POWELL: You know, I spent a day at one of the MOI clinics down south of Baghdad about -- it's probably a month ago now. And the area is predominantly Sunni. And the national police forces and the people who are staffing and manning the clinic are Shi'a.

And the clinic was not to treat folks who were in the police force but to treat the local populace; to check the kids out, see if they needed immunizations or had something that could be, you know, that they could treat with antibiotics, or if there was some specific issue they could work with.

And one of the interesting pieces was that they have -- this is what's called a CMO or a civilian medical operation and civil medical operation. And they had attracted the local populace in to see these folks. And the national police force at this clinic was most proud of the fact that the local folks

would walk in the gate, as Sunni by and large into this compound, which was predominantly run by folks of Shi'a. And they we're comfortable coming in and out, and it wasn't a big deal.

Now, this is not the first time they had run this CMO. It won't be the last. But they were proud of the fact that they had made it comfortable for folks, regardless of what their predominant sect was, to come in, get what medical care was available and go on their way. And by and large, they left with a smile on their face.

So I was kind of surprised by that truthfully. But that was -- that's something, I think, we've all seen, at least the members of the office here. Because we spend a lot of time on the road and out in the clinics watching them do stuff. And that's been the predominant scenario.

It's not perfect everyplace but it certainly was a big issue there. They made a point of saying, these folks, you know, are not us but they're comfortable coming here. They bring their families here, which is the real big issue. And we take care of them and give them what we have. And they're happy with that.

LT. CRAGG: Okay, sir. I think we're running out of time. If you want to, close with any closing statements, if you'd like.

COL. POWELL: Sure.

They've come a long way in five years. I don't think there's any question in my mind, I think, folks who have been here in the past. It ain't perfect. They've got a long ways to go but they have some direction.

And the biggest piece right now is manning, is personnel, people who have medical -- from my standpoint anyway -- who have medical capabilities, who can do what's necessary, to diagnose people and take care of them and also to do the preventive stuff ahead of time, to help make sure that the water is clear, to help make sure that we have -- that they have manned staff facilities that can do simple, straightforward medicine, which is really what they need here.

And that's, I think, probably the thing that I'll get the most from my time here over the course of the last few months and a few more. They know. They have a direction. They know what needs to be done. They're working hard to get the people to come back, who are trained and outside. And mostly those are senior folks that can come in and teach and help get things back on what we would call a direct road to taking care of folks.

So there's no question in my mind, they know what needs to be done. They've got some direction with it and they're headed that way. And I would love for it, to see it all happen tomorrow. And I think most of them would too. But it's going to take some time to build it.

LT. CRAGG: Thank you, sir, for that closing statement. And with that, I just wanted to so thank you for everyone for attending.

And just as a wrapup, the program will be available on the bloggers link on dod.mil, where you will be able to access a story based on today's call as well as the audio file, the bio and the transcript. Sir, again, thank you for joining us. And thank you for the bloggers.

COL. POWELL: You bet.

Q Thank you.

LT. CRAGG: This concludes today's event.

END.