Durham, NC – On 10 OCT 2012, in celebration of National PA week, The Womack Army Medical Center Interservice Physician Assistant Program (WAMC IPAP) and Fort Bragg PAs visited the Stead Center in Durham, North Carolina. The Stead Center is an important part of celebrating PA week primarily because Dr. Eugene Stead, Jr. is recognized as the founding father of the physician assistant profession. This was also a momentous occasion for IPAP because last year during National PA week, our first visit left an impression upon us to leave a lasting legacy and contribute to the history of physician assistants. 1LT Christopher Mueller of Class 2-10 solicited contributions from his fellow IPAP students with their contributions being matched by the IPAP faculty. During 2012 SAPA
Conference, the attendees also donated enough funds to meet our goal for the bench.

Our visit included a presentation of the history of the physician assistant profession that was provided by Mr. Michael Borden, CEO of the center, where the students learned about how the profession started and where we are today. He also discussed several of the memorabilia and historic publications that were in the center. We then walked around the center that included a replica of Dr. Stead’s office.

We then walked to the beautiful garden where MAJ Amelia Duran-Stanton said a few words on how the bench project came about. CPT Jason Dillashaw and CW³ Antonio Ruiz, current class leaders, then unveiled the bench and everyone posed to take pictures. We want, in the future, for all Stead Center visitors to sit on the bench and reflect upon the history of the physician assistant profession and how the military has an important part of that history. The bench is dedicated to the men and women of the armed forces and the health care providers who care for them.
Overall, the students and PAs were thankful for the opportunity to visit the center and to dedicate a lasting contribution to the center for future attendees can enjoy while reflecting on our history.

By MAJ Amelia Duran-Stanton

Then OC Christopher M. Mueller (now 1LT) with the initial presentation and idea of the IPAP Bench.

The plaque that was placed on the bench. It represents all military PA; Past, Present, and Future.

Seated from L to R: 1LT Larissa Williams, OC Jessica Trosper, CPT Joanna Robertson, MAJ Amelia Duran-Stanton (WAMC IPAP Clinical Coordinator)

Standing from L to R: CPT Jason Dillashaw, MAJ Dustin Martin (82nd Airborne Division Senior PA), LT Roland Salazar, OC Jared Breese, Mr. Michael Borden (CEO of the NCCPA), OC Juan Grado, OC Stephen Witte, CW3 Antonio Ruiz, and Mr. Joseph Cohen (orthopaedic physician assistant and WAMC IPAP orthopaedic primary preceptor)
Recent Major’s List Of our fellow PA’s

Below is a list of our newly selected Majors

CPT (P) James Andrews (65D)
CPT (P) John Berg (65D)
CPT (P) Benjamin Blanks (65D)
CPT (P) Nicolas Bradley (65D)
CPT (P) Jerry Braverman (65D)
CPT (P) Aaron Caldwell (65D)
CPT (P) Christopher Dominguez (65D)
CPT (P) Tracie Dominguez (65D)
CPT (P) John Donoughe (65D)
CPT (P) Erin Driver (65D)
CPT (P) Joseph Eddins III (65D)
CPT (P) Karen Fish (65D)
CPT (P) Kurt Fossum (65D)
CPT (P) Maureen Giorio (65D)
CPT (P) Alhambro Gordon (65D)
CPT (P) Daniel Hankes (65D)
CPT (P) Christopher Harris (65D)
CPT (P) James Hart (65D)
CPT (P) Robert Helm (65D)

CPT (P) Mario Heredia Blanco (65D)
CPT (P) Seth Holland (65D)
CPT (P) Ronald Holmes (65D)
CPT (P) Wayne Johnson (65D)
CPT (P) Ryan McGill (65D)
CPT (P) Richard Newport (65D)
CPT (P) Michael Ramos (65D)
CPT (P) Andrew Schano (65D)
CPT (P) Joshua Shehan (65D)
CPT (P) Michael Shorttt (65D)
CPT (P) Michael Singer (65D)
CPT (P) Trina St. Ann (65D)
CPT (P) William Taylor (65D)
CPT (P) Lauris Trimble (65D)
CPT (P) William Vasios (65D)
CPT (P) John Walker (65D)
CPT (P) Craigreon Wallace (65D)
CPT (P) Patrick Walsh (65D)
CPT (P) Harold Yu (65D)
Abstract
This essay will encompass the ethical dilemma with cultural sensitivity, the moral obligation/medical responsibility to include the Hippocratic Oath, and the internal conflict experienced by Special Operations Forces (SOF) medical personnel when faced with cultural diversity as a restraint to rendering medical aid. As a SOF Physician Assistant (PA) on a mission to support a Company level operation, cultural diversity rendered U.S. medical aid irrelevant. However, although restricted from hands on treatment, through persistence, diplomacy, and cultural awareness, SOF Medicine did make a difference in the life of an Iraqi Mother and her newborn child.

Medical professional’s obligation to uphold the Hippocratic Oath can intersect with local social taboos, often resulting in ethical conflicts. Comprehending foreign customs and culture can be difficult, excruciatingly complex, and is further strained in a combat environment. As a Special Forces Physician Assistant, I’ve stood at these moral crossroads, when cultural restrictions prevented me from touching an exsanguinating patient. This situation both mystified and infuriated me, and raised ethical considerations that have confused me for years. Soldiers have engrained experiences from combat; many are tragic and some are more positive.
An experience of mine describes this clash of 21st century medicine with Iraqi Culture, and is one of my most confusing clinical experiences. Although bleeding and in shock, an Iraqi woman would not allow two of my Special Forces (SF) medic [18 Delta (18D)] colleagues or me to touch her in order to render post-natal medical care. She had been bleeding for approximately 6-8 hours. The ethical dilemma and circumstances surrounding the medical situation caused me to repeatedly re-evaluate and reassess my moral stance, cultural differences, ethical ramifications, and medical decisions. Therefore, I see it as necessary to describe this encompassing ethical dilemma and the associated cultural competencies, moral obligations, and medical responsibility inherent in the Hippocratic Oath. Additionally, I will describe the internal conflicts we experienced as a band of Iraqi village women –presumably defending their culture-refused our efforts to render aid.

In the winter of 2008, during a mission in the Hamrin Mountains, SF Soldiers captured several targets for questioning. Tensions are typically high when conducting such operations, as security is always balanced with the desire to minimize negative local perception of our actions. During this operation, our Sergeant Major yelled “Doc, a woman is having a baby in one of those huts!” We recognized the opportunity to render assistance. Upon arrival at the small mud hut home, I found two of my 18D colleagues distressed: they were caught in an ethical and emotional conundrum in which they were unable to make a positive impact on the clinical outcome of a post-natal Iraqi woman.

This woman had had been bleeding continuously since giving birth 6-8 hours prior. She had not been able to feed her obviously hungry and crying baby since delivery. The other village women, to include the presumed matriarch, would not allow us to help her. The interpreter told us that if the women allowed us to place our hands on her to control bleeding, upon his release from questioning, her husband would kill her. The cultural taboo against another man touching someone else’s wife was strong enough to prevent us delivering care, even at expense to her life.

At its core, this Western, Hippocratic ideal of “first, do no harm” morphed into “do nothing and the patient dies.” Through our interpreter, we were able to convince the matriarch that intravenous infusion would be
of great benefit if she would allow us to help stop the bleeding first. Two 18D colleagues and I pooled our resources of Kerlex bandages together and told the interpreter to explain to the matriarch what had to be done. Soon after that conversation, we were forced out of the hut so the women could stop the bleeding.

Upon re-entering the hut, we noted that approximately half of the Kerlex had been used to clean the already pooled blood off the floor, and we could only hope that the other half had been used for what it was originally intended. The 18Ds established intravenous (IV) access, and infused two bags of fluid which had an immediate impact on her blood pressure and overall clinical status. Throughout the entire process, the temperament of the village women was very unsettling. We left instructions with the matriarch and the rest of the Kerlex. The patient’s blood pressure was stable and much better than when we initially arrived. She was sitting up and conversing with the matriarch and the other village women when we left. We had also found out that this was her fourth child.

As a Special Operations Forces (SOF) clinician and Soldier, I still think about that woman. I wonder whether she and her infant survived the immediate post-natal and post-partum period. More pressing is wondering if her husband exercised his cultural “right” to punish her, and if we did the right thing. Ethical decisions versus customs and cultures of another country are how I delineate the decisions made that day. Although certainly debatable, in ethically justifying our actions in my own mind, I thought of “Consequentialism in which rightness is based on the consequences of an act rather than the act itself.” Our intentions were of the highest order, to save her life.

In reflection on our Hippocratic and moral obligations, I wonder if our restraint to not render aid where we knew it was warranted was ethically appropriate. Most SOF clinical providers, especially 18Ds, have experienced morally ambiguous and traumatic situations when treating combat casualties. Despite my experience as a SOF Physician Assistant (PA) in placing emergency airways, treating numerous burns, shrapnel and traumatic brain injuries (TBI), sewn hundreds of sutures and treated high-velocity missile injuries during many tours in Iraq. However, those traumatic situations were the direct result from war, not a non-combatant post-natal woman bleeding.

“I will remember that I remain a member of society with special obligations to all my fellow human beings, those of sound mind and body as well as the infirm.”
out on the floor of her mud home in the mountains of Iraq, who refused treatment from fear that her husband would kill her (because of their culture). The Hippocratic Oath states, “I will remember that I remain a member of society with special obligations to all my fellow human beings, those of sound mind and body as well as the infirm.” I took this Oath 15 years ago when I became an 18D and again as a SOF PA. The meaning continuously resonates within me, and made me take a hard look at the decision I made that day in attempting to help another human being.

Part of me wanted to push past the matriarch and the other Iraqi women to get to my patient and help her, regardless of what the second and third order effects would be. However, the patient also refused care as the interpreter tried to convince her that we were there to help her. “Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.” Helping too much could have cost the woman her life at the hands of her own husband. Not helping at all could have cost the woman her life by exsanguination. Did we do enough?

Thirdly, the disturbed feeling of helplessness and internal conflict in treating the bleeding Iraqi woman was reduced as my attention became focused on the newborn baby. For reasons unknown to us, the matriarch would not allow 18Ds or me to see the newborn baby. My concern was when the baby would be fed, especially if the mother did not survive. Through the interpreter, I explained to the matriarch that if we could get the bleeding mother to breast feed, this could stimulate uterine contractions and thereby decrease or possibly stop the bleeding. I kept trying to make an accurate assessment of the amount of blood loss in the blankets and on the floor from the bleeding woman, but the matriarch was adamant about keeping my men and me at bay.

The mother refused to breastfeed her newborn. This was a new problem to address. The quickest resolution to the problem that was easily attainable was the old world “wet nurse” concept. Through the interpreter, I asked the matriarch if there was a new mother in the village. She understood the idea and sent for her immediately. The young new mother arrived and agreed to feed the newborn baby. The internal conflict and
feeling of helplessness was somewhat subdued by knowing that my 18D colleagues and I had made some impact on the immediate needs of the newborn baby. Our perseverance paid off and allowed for this simple but viable option. Although their customs initially rendered our medical training useless, our critical and creative thinking, and diplomacy allowed some level of care delivery.

As a result of eleven years of continuous war, military medicine has experienced incredible technological advancements in trauma management. The constant influx of new products and advanced training has dramatically improved patient survivability from point of injury to a higher echelon of medical care. However, some challenges cannot be addressed through technology or medical training alone. Sometimes, even cultural awareness and a broad spectrum of interpersonal skills are not enough. Special Forces Soldiers are our Nation’s military ambassadors. We are linguistically and culturally diverse in our specific areas of operation; have many skills sets, five primary functions and multiple other special duties. We take pride in our cultural sensitivity and ability to work by, with, and through, but still face great challenges regarding gender-specific cultural restrictions.

In conclusion: retrospectively, after analyzing this scenario multiple times and conducting my own internal after action review, the only idea that continuously presents itself as a viable option is that having a female provider/medic available could have negated all of this. The difficulty is foreseeing this type of problem occurring. A female medic assigned to a company-sized SOF mission in an Arab nation could be a great benefit, not only in helping American Forces win the hearts and minds but even more importantly, helping save a human life.

My own professional medical judgment to render aid to another human being was brought into question in this situation. Our medical judgment had to take the customs and culture of a tribal village in the Hamrin Mountains of Iraq into consideration or take the risk that our actions would result in the murder of a mother, further damaging any future relationship. The Special Forces community has
to take customs and culture into consideration and it is not our position to question them. As military ambassadors, the SF community must work creatively within the limitations set forth by the culture in which we are immersed. Our limitations were apparent within the cultural differences that day: between what we expect to be the norms of our society and what the matriarch and Iraqi village women knew to be their own ways.

**Editors**

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**Work Cited**


U. S. Department of the Army, FM 4-25.11, FIRST AID (INCL CHANGE 1) PDF. December 2002.
**Biography**

Major Larry Wyatt is a Special Operations Forces (SOF) Physician Assistant (PA) with ten years of experience. He is currently a student at the Command General Staff College (CGSC) in FT. Leavenworth, Kansas. Prior to CGSC he served as the 5th Group Dive Medical Officer and is an Aeronautical (PA). He has a Bachelors Degree in Health Science and a Masters Degree in Physician Assistant Studies. Major Wyatt has more than four years of combat deployments into Iraq and multiple deployments throughout Central and South America as a prior Special Forces Medic (18D). Major Wyatt can be contacted through his AKO at larry.a.wyatt@us.army.mil.
New PA’s in New Positions
These are unprecedented times where PA’s are reaching new heights!
Please join me in congratulating these officers.

I am pleased to announce the individuals selected for the following positions:

- **G3/5/7**
  - LTC/P John Balser

- **FORSCOM PA Consultant**
  - LTC Paul Jacobson

- **Ft Stewart IPAP PH II Coordinator**
  - MAJ Dale Sharp

- **Ft Bragg IPAP PH II Coordinator**
  - MAJ Scott Festa

- **2nd Infantry Division PA**
  - CPT/P Patrick Walsh

- **3rd Infantry Division PA**
  - MAJ Scott Harrison

- **1st Cav Division PA**
  - MAJ Walt Engle

- **82d Airborne Division PA**
  - MAJ John Elliott

- **USAREC/IPAP Program Manager**
  - MAJ Scott Bradshaw

- **USAEUR PA Consultant**
  - MAJ Johnny Paul

- **TCMC Instructor**
  - CPT Jason Adams and CPT James Winstead

- **MTF Drum, Orthopaedics DEPT**
  - CPT Robyn Chalupa

Of particular note, we had some folks compete for nominative positions and the following individuals were selected:

- **Brigade Commander, Bethesda MD**
  - LTC Rick Villarreal

- **Aide de Camp, Pentagon IG**
  - MAJ Bill Soliz

- **Deputy Director for MEDCOM IG**
  - MAJ Amelia Duran-Stanton

- **Deputy Surgeon, Cadet Command**
  - MAJ Dawn Orta

- **541st FST Commander**
  - MAJ Cleve Sylvester

- **240th FST Commander**
  - MAJ Chad Cole

- **DARPA Fellow**
  - MAJ George Barbee

- **SP Executive Fellow**
  - CPT Paul Mochmer

- **Company Command**
  - CPT Mike Delavega

- **Company Command**
  - CPT Antonio Chang
This patient's symptoms turned out to be from an uncommon condition—but one that should always be considered in the evaluation of abdominal pain in adults.

**CASE**

A 20-year-old white female presented to the emergency department (ED) with low back pain that radiated to her left anterior/superior hip. The patient stated that she had had hip pain on most days of the week for the past 4 months. The onset of the pain was intermittent, and the patient described it as aching and spasmodic. At its worst, the pain was 10 on a 10-point scale by patient rating. There was no temporal relationship of the symptoms. The pain was somewhat relieved by tramadol (Ultram), 50 mg by mouth 3 times a day, and acetaminophen with hydrocodone, 500 mg/5 mg by mouth every 4 to 6 hours for moderate to severe pain. These medications had been prescribed by the patient's primary care provider.

The patient had undergone an extensive workup for her pain over the past 4 months. This workup included 13 radiologic studies consisting of plain films of the back, hips, and pelvis; a three-phase nuclear medicine study; and MRI of the left hip. The results of all these studies were normal.

The patient also reported an occasional fever at night up to 101°F (38.3°C, oral) and occasional nausea and diarrhea without blood, pus, or mucus. She denied any headache, chills, vomiting, visual changes,
neck stiffness, shortness of breath, chest pain, symptoms of urinary tract infection, irregular menses, or gait changes. The patient had never been pregnant, and her last menstrual period was 9 days earlier. She had no history of trauma or lumbar puncture. She had no risk factors for cardiac disease, pulmonary embolism, or deep venous thrombosis. Her immunizations were up-to-date. She had no prior surgeries or significant family history. She did not use tobacco, alcohol, or illicit drugs. She had no history of intravenous drug use. Her last skin tattoo was placed 8 months previously. Her last sexual contact was 6 months previously. She had no history of recent travel, camping, or exposure to insects or animals. She had no drug allergies. Her diet history was not clinically significant.

**On physical examination**, vital signs were as follows: temperature, 97.4°F (rectal); pulse, 68 beats per minute; respirations, 16 breaths per minute; BP, 110/72 mm Hg; and oxygen saturation, 99% on room air. The patient's general appearance was of a healthy, athletic female; she was in obvious pain, diaphoretic, alert, oriented, and responsive to questions. Her head was normocephalic and atraumatic, and her pupils were 4 mm, equal, and reactive to light. The ears were clear, and tympanic membranes were mobile; the nose was without discharge; and the oropharynx was clear, with moist mucous membranes. The neck was supple, without jugular venous distention, and the trachea was midline. Breath sounds were clear bilaterally. The chest was not tender to palpation, and the breasts were without masses. Heart rhythm was regular and without murmurs, and pulses were equal. The abdomen was soft without distention, and bowel sounds were normoactive. The patient had slight tenderness to palpation in the left lower quadrant near the left anterior superior iliac spine. Otherwise, there were no masses, guarding, or rebound tenderness; obturator and psoas signs were absent. The spine was straight without deviation or crepitus, with tenderness to palpation at
the L-4 left paraspinal area. The straight leg raise test was negative to 80 degrees. The pelvic examination revealed normal female genitalia, with a nulliparous, closed cervical os. There was no discharge, cervical motion tenderness, suprapubic tenderness, adnexal tenderness, or masses. The rectal examination showed normal tone, stool in vault, no gross blood, and was negative for occult blood. There was no extremity swelling, edema, limb tenderness, or joint tenderness. The patient had several tattoos on her arms, back, and stomach, but her skin was otherwise clear. Cranial nerves II through XII were intact, muscle stretch reflexes were 2+, and strength was 5/5, with sensation and proprioception intact. The patient's gait was normal.

**Laboratory studies** revealed the presence of leukocytosis (23,100 WBCs/mm³, with 90% neutrophils). The results of urinalysis and tests for electrolytes, liver function, and kidney function were all normal. Blood cultures, a pregnancy test, a fecal occult blood test, and cultures for sexually transmitted infections were obtained, and all results were negative. A portable anterior/posterior chest radiograph was normal. The previous radiologic studies were also reviewed again and found to be normal. Meningitis, encephalitis, pneumonia, pulmonary embolism, mesenteric ischemia, large bowel obstruction, pelvic inflammatory disease, ectopic pregnancy, septic arthritis of the hip, hip fracture, lumbar fracture, and spinal neurologic compromise were ruled out based on the chief complaint, patient history, review of systems, and physical examination. The initial differential diagnosis included musculoskeletal back pain, spinal abscess, osteomyelitis via hematogenous spread, left ovarian pathology, or an infectious process.

During the patient's stay in the ED, pain control was achieved with 1 g of acetaminophen (Tylenol) by mouth and IV administration of 5 mg of valium (Diazepam). Abdominal ultrasonography was considered initially, but based on review of the patient's previous studies and presentation, her previous workups, and the differential diagnosis, CT of the abdomen and pelvis with IV and oral contrast was ordered instead. CT was chosen because it would allow evaluation of the abdomen, pelvis, and skeletal structures. CT revealed a 3-cm small bowel (enteroenteric) intussusception through five slices at the splenic area (see Figure 1 and Figure 2). The surgeon on call was consulted, and the patient was admitted to the surgical service for further workup.

**DISCUSSION**

Intussusception occurs when a proximal segment of bowel telescopes into the lumen of the adjacent distal segment. Although considered rare in the adult population, approximately 5% to 16% of intussusceptions in the Western world occur in adults.¹ Most children present acutely, but adults may have acute, subacute, intermittent, or chronic symptoms.² In contrast to children, where 80% to 90% of intussusceptions are idiopathic, adult intussusception has a demonstrable cause in more than 90% of cases.³ If left
untreated, intussusception can lead to intestinal obstruction.

One retrospective hospital case review spanning 30 years identified 58 adult intussusceptions; the mean patient age was 54.4 years, with a male predominance ratio of 1.8:1, higher enteric versus colonic location (44:1), and slightly higher benign pathology.² Another hospital case review spanning more than 25 years identified 25 intussusceptions; the mean patient age was 52 years, with a slightly higher male predominance and a slightly higher malignant pathology identified.³

**Three types** of intussusception can occur, based on location in the bowel: enteroenteric, colocolic, and enterocolic. Enteroenteric intussusception involves only the mesenteric small bowel and is further categorized by the specific small bowel segment involved. Colocolic intussusception involves the colon and is categorized by the specific segment of large bowel involved. Enterocolic intussusception involves both small and large bowel, with two specific subtypes: ileocolic and ileocecal.¹

The etiology of most childhood intussusceptions is idiopathic, with recent data implicating lymphotropic
viruses as the cause. In the adult patient, there is usually a definable lead point, with neoplasia being the most common etiology. Transient, nonobstructing, symptomless intussusception is known to occur in adults, but only a few published cases illustrate the classic features on CT. Some causes of this type of intussusception have been associated with known or suspected celiac disease or with Crohn's disease.

The presenting signs and symptoms of adult intussusception are highly variable. The most commonly described symptom is crampy abdominal pain, noted in 75% to 85% of patients. Less frequently reported symptoms are nausea, vomiting, diarrhea, and constipation. Only in a minority of patients are bleeding and a palpable abdominal mass appreciated. One surgical case series of 58 adult patients with intussusception noted some interesting findings. In malignant colonic intussusception, patients were more likely to have melena or guaiac-positive stools; patients with benign enteric intussusceptions presented mainly with abdominal pain, nausea, and vomiting.

Computed tomography remains the most useful and accurate study for detection of intussusception in adults. CT will show the dense composition of the intussuscepted mass comprised of edematous bowel wall and mesentery within the lumen with a characteristic “target” sign or sausage-shaped appearance. Although the identification of intussusception can be made confidently on CT, the underlying cause may be difficult to determine. In one study of 16 patients with intussusception, CT was able to correctly identify the causative pathology in only two cases where a lipoma acted as a lead point.

Ultrasonography can be used to evaluate suspected intussusception in adults and is the second most accurate diagnostic study. The classic features of intussusception on ultrasound include the donut and target signs on the transverse view and the pseudokidney sign on the longitudinal view. In one case series, sonography confirmed the preoperative diagnosis of intussusception in three out of four patients. The advantages of sonography are its speed, relative lack of expense, avoidance of radiation and con-
contrast, and the ability to obtain real time data. The limitations of this imaging modality include operator variability, overlying bowel gas, difficulty imaging obese patients, and identification of the underlying cause.1,5

**The optimal treatment** for adult intussusception remains controversial. For small-bowel intussusception, reduction is attempted initially unless inflammation, bowel ischemia, or malignancy is suspected. In most cases of colonic intussusception, primary resection without reduction should be performed—especially if the patient is older than 60 years, when the incidence of malignancy is high.5

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**CONCLUSION**

This case represents a typical ED visit for a female patient with a history of chronic, vague abdominal and back pain. Based on the patient's history and earlier workups, the PA could easily have reviewed the previous studies, treated the patient symptomatically, and discharged her with good follow-up precautions. What prompted further investigation was the history of intermittent febrile episodes with nausea and diarrhea. The findings of left-sided abdominal pain with leukocytosis and a left shift also were pertinent. The previous studies ruled out an extremity-based musculoskeletal source, as discussed earlier.

This case illustrates the importance of a good clinical decision-making process and the value of reviewing previous studies when these are available. Although intussusception was not in the initial differential diagnosis, the patient's elevated WBC count, nausea, and occasional febrile episodes could not be explained. This led to the review of the patient's previous studies, the choice of CT, and an accurate diagnosis. The cause of the intussusception was never determined in this patient. **JAAPA**

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**Acknowledgment:** The author would like to thank Dr. Bruce D. Adams, LTC(P), MC, USA, Chief of Emergency Medicine Services, Brooke Army Medical Center, for his guidance with this manuscript.

The opinions or assertions contained herein are the private views of the author and not to be construed as official or as reflecting the views of the US Army Medical Department, Department of the Army, or the Department of Defense. Citation of commercial organizations and trade names in this manuscript do not constitute any official Department of the Army or Department of Defense endorsement or approval of the products or services of these organizations.
REFERENCES


George Barbee practices emergency medicine at Womack Army Medical Center, Fort Bragg, North Carolina. He has indicated no relationships to disclose relating to the content of this article.

From the October 2008 Issue of JAAPA

In the coming weeks will be our Society of Army Physician Assistant (SAPA) Conference which is held annually in Fayetteville, North Carolina. We know that Mr. Potter is working hard to ensure that it will be a very good conference; I know personally from the one that I attended it was very informative, on a professional and personal level.

In the preceding pages are SAPA membership forms, Conference registration and this year’s Conference itinerary. I apologize before hand if the forms are distorted due to Newsletter margin constraints, but they can still be accessed via our website: www.sapa.org.

I hope that everyone is able to attend the conference this year to continue their medical education and to meet old and new friends. Unfortunately I will not be able to attend this year due to my current deployment to Afghanistan. I hope to see most, if not all, of you next year.
# SAPA Newsletter

## Application for Membership

**Type of Application:**
- [ ] Initial
- [ ] Renewal
- [ ] Change of Address/Info

**Rank:**
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- [ ] First Name
- [ ] MIl.

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**Phone:**

**Work FAX:**

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- [ ] Active
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- [ ] NG
- [ ] Retired Civilian
- [ ] Other Military Service (Please Specify)

**Current Assignment:**

### Professional Information

- [ ] ASH/PA PA Class No.
- [ ] Location of Preceptorship
- [ ] Dates Attended
- [ ] Name/Location of Civilians/other military PA Program
- [ ] Dates Attended
- [ ] NCCPA #: [ ] Expiration Date
- [ ] AAPA #: [ ] Expiration Date

**Do you wish to name SAPA as your constituent chapter of AAPA?**
- [ ] Yes
- [ ] No

**Highest Education Degree Attained:**
- [ ] AA
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**I hereby authorize SAPA to release information on this application to:**

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**No portion of your membership dues are used for lobbying purposes.**

### Dues

- [ ] Fellow/Associate/Affiliate: $25.00/year
- [ ] Fellow/Associate over 65yr: $15.00/year
- [ ] Student: $5.00/year

**You may pay for multiple years @ $22.00/year**

Please mail dues to the address listed below:

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*I authorize SAPA to Charge My Credit Card for payment of my dues* (print and sign name as shown on credit card)

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**Signature Required for Credit Card Use:**

**Mail Form to:** SAPA, PO BOX 4068, Waynesville, Missouri, 65583 or fax to: (888) 711-8543

**Office Use Only:**

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Dear Fellow Medical Professional:

I am pleased to announce registration for the 34th Annual SAPA PA Refresher Course is open. Our course is both challenging and relevant in your role as a health care provider. The agenda has been structured to address those areas that require frequent update in the ever changing field of medical and health care delivery. The program provides lectures given by guest speakers from leading medical schools and practice settings from across the nation. It also includes a variety of complimentary entertainment and events. Take a moment of your time to fill out your registration form below to ensure your spot at our course in April. See you in Fayetteville!

Bob Potter, PA-C, MPAS
Conference Coordinator

**When:** 22 April - 26 April 2013

**Location:** Holiday Inn at I-95 Hotel & Convention Center, 1444 Cedar Creek Road, Fayetteville, North Carolina

**Category 1 CME:** This program has not yet been approved for CME credit. Conference organizers plan to request 30+ hours of Category 1 CME thru the AAPA

**Enjoy the Complimentary Banquet, Live Entertainment & Golf Tournament!**

Registration Form Please type or print form! No registrations accepted by mail postmarked after April 5th 2013, we are only able to accept Faxed Registrations until April 12th 2013. After that date, please register on site!

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AAFA Number: ________________________ Expiration Date: ________________ Do you choose SAPA (Army) as your constituent chapter with AAFA - YES - ☐ No - ☐

I do ☐ do not consent to the release of my name and address to pharmaceutical representatives and speakers present for the refresher course.

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<td>☐ $33 SAPA Membership Dues (complete enclosed) (Membership Year from 1 July 2013 to 1 July 2014 for new members)</td>
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Total Enclosed: ________________________ Payment Must Be Received In Full Prior To Being Officially Registered!

Method of Payment: Cash ☐ Check ☐ Credit Card ☐ (SAPA is now able to accept M/C, Visa and American Express)

Credit Card (Circle) M/C Visa Amer Exp Credit Card No __________________________ Exp Date ________________

If there is a problem with a credit card or check, the individual may be contacted by the SAPA Treasurer (Jim Miller)

I authorize SAPA to Charge My Credit Card the above Conference Registration Fees. SAPA reserves the right to charge the correct amount if different from the total payment listed above.

Signature Required for Credit Card Use: __________________________

Printed Name and Phone Number of Authorizing Signature: __________________________

Confirm your registration today! 34th Annual SAPA Refresher Course

Mail registration form and payment to: ATTN: SAPA Coordinator, Bob Potter, PA-C

P.O. Box 623

Monmouth, Illinois 61462
2013 SAPA Conference Itinerary

Saturday April 20, 2013
0800-1700 Setup of Display Room & SAPA Offices - Holiday Inn at I-95 Convention Center

Sunday April 21, 2013
1200-1700 Conference Registration – Holiday Inn Main Lobby
1200-1700 Pharmaceutical Set Up of Display, (Dogwood Room) Holiday Inn Convention Center
1500-1900 “SAPA Welcome Reception” DJ Music by “” Holiday Inn at I-95

Monday April 22, 2013
0630-1700 Conference Registration
0730-0800 Opening Remarks ; Holiday Inn Ballroom
0800-0900 Overview of Forensic Medicine, Presented by CAPT. Edward Reedy, MD, PhD
0900-1000 AFMES Organization and Mass Fatality Processing, Presented by CAPT. Edward Reedy, MD, PhD
1000-1600 US Army Active Duty Physician Assistant HRC Interviews, Room 2032, Holiday Inn, I-95 (If Available To Attend)
1000-1100 Overview of Pain Management, Presented by Tim Phillips, PA-C
1100-1200 Advanced Pain Management, Presented by Tim Phillips, PA-C.
1200-1300 Lunch on your own!!!!
1300-1400 Endocrinology You Love To Hate, Presented By Patricia Lucas, PA-C
1400-1500 All You Ever Wanted To Know About CHF, But Were Afraid To Ask, Presented By Patricia Lucas, PA-C.
1500-1600 Today It Would Be Malpractice –Medical Malpractice & George Washington, Presented By Robert Hufford, PA-C
1600-1700 Up To Date Screening In Men’s and Women’s Health, Presented by Anook Toussaint, PA-C
1700-2000 National Guard & Reserve Representative Briefing/Meeting Location TBA
1700- Break for Dinner
1800-2000 SAPA President’s Reception, Poolside Holiday Inn I-95
(Golf Tournament Location TBA during Reception)
2000-0000 Evening Entertainment ; Courtyard at Holiday Inn at I-95
Tuesday April 23, 2013
0800-1700 Conference Registration – Holiday Inn Main Lobby
0800-0900 Managing Chronic Opiate Therapy, Presented by Ron Byerly, PA-C, Supported By Geisinger
0900-1200 SAPA BOD Meeting, Room 2070, Holiday Inn at I-95
0900-1000 Diagnosis & Treatment of Common Shoulder Injuries, Presented by Joseph Cohen, MPAS, PA-C
1000-1600 US Army Active Duty Physician Assistant HRC Interviews, Room 2032, Holiday Inn, I-95 (If Available To Attend)
1000-1100 Updates in the Management of Hypertension, Presented by Dr. Simon Herold, MD.
1100-1200 Common Pediatric Fractures & Sports Injuries, Presented by Joseph Cohen, MPAS, PA-C
1200-1300 Lunch on your own!!
1200-??? EKG Workshop, Presented Patricia Lucas, PA-C, Additional charge for supplies TBA, sign up on site, limited seating
1300-1400 Oh No! Anything But That, Presented Carl Fusco, MD.
1400-1500 Homeopathy Basics, Presented by Carl Fusco, MD
1500-1600 Methadone – If You Are Going To Dance With The Devil, Pick Your Own Music, Presented by Mark Traugh, PA-C
1600-1700 Overview of Renal Disease, Presented by Mark Traugh, PA-C
1800-2000 Break for Dinner
2000-??? Entertainment – Karaoke Provided By “JAMMIN JIMMY”
2000-??? Entertainment – “Casino Night” Provided By “Snake-Eyes & Poker Queen”

Wednesday April 24, 2013
0800-1700 Conference Registration – Holiday Inn Main Lobby/SAPA Office
0800-0900 Acute Hand Injuries and Infections, Presented By Maj. Susan Fisher, PA-C
0900-??? 34th Annual SAPA Hackers & Whackers Golf Outing,
0900-1000 Orthopedic Urgencies and Emergencies, Presented By Maj. Susan Fisher, PA-C
1000-1600 US Army Active Duty Physician Assistant HRC Interviews, Room 2032, Holiday Inn, I-95 (If Available To Attend)
1000-1100 Exertional Rhabdo, Presented By Scott Fisher, PA-C
1100-1200 Stasis Ulcers – I see Them in The Office, Now What, Presented By Tammy Straka, PA-C
1200-1300 Lunch on your own!!
1300-1400 ARDS – Everything You Wanted To know, But were Afraid to Ask, Presented By Mike Straka, PA-C
1400-1500 **SCUBA Medicine, Part 1**, Presented by Mike Wright, PA-C
1500-1600 **SCUBA Medicine, Part 2**, Presented by Mike Wright, PA-C
1600-1700 **Ventricular Assist Device Management**, Presented By Brian Arndt, RN, Supported by Geisinger
1800-2000 Break for Dinner
2000-???? **Entertainment - Music by “JAMMIN JIMMY”**

**Thursday April 25, 2013**
0800-1700 **Conference Registration** – Holiday Inn Main Lobby/SAPA Office
0800-0900 **Lethal Cutaneous Skin Lesions**, Presented by R. Keith Bailey, PA-C
0900-1000 **Domestic Violence – A Cop’s Prospective**, Presented by R. Keith Bailey, PA-C
1000-1600 **US Army Active Duty Physician Assistant HRC Interviews**, Room 2032, Holiday Inn, I-95 (If Available To Attend)
1000-1100 **Traumatic Brain Injury In The Military**, Presented By Taija Broadwater, PA-C, Supported by Geisinger
1100-1200 **Evaluation & Treatment of Pleural Effusions**, Presented By Nevin Gorki, PA-C, Supported by Geisinger
1200-1300 Lunch on your own!!!
1300-1400 **Bullet, Blasts & Bombs**, Presented by Robert Cowan, PA-C
1330-1630 **SAPA General Membership Meeting**, Barons, Holiday Inn, I-95
1400-1500 **Who Comes First? Triage In The Field**, Presented by Robert Cowan, PA-C
1500-1600 **Don’t Believe Everything You Read, Medical Evidence & Thomas Jefferson**, Presented By Robert Hufford, PA-C
1600-1700 **Update on Eye Injuries**, Presented by Irwin Fish, PA-C
1800-1900 **“Cocktail Hour”**, Foyer Area, Holiday Inn, I-95
1900-2100 **34th Annual SAPA Banquet** Grand Ballroom Holiday Inn, I-95
2100-???? **Dance The Night Away With The Sounds of “” Assorted Music for Young and Old**

**Friday April 26, 2013**
0800-0900 **Correctional Medicine**, Presented By Irwin Fish, PA-C
0900-1000 **Renal Calculi Or Labor, Which Is Worse**, Presented By Karen Reedy, PA-C
1000-1100 **Scabies On The Reservation**, Presented by Karen Reedy, PA-C
1100-1115 **Conference Adjournment!!! Have a Safe Trip Home, Hope to see you next year!!**
THIS IS A PRELIMINARY SCHEDULE, UP TO DATE CHANGES ARE AVAILABLE AT THE SAPA WEB SITE – www.sapa.org

PURPOSE
The 34th Annual Society of Army Physician Assistants Refresher Course is dedicated to the education of the Physician Assistant (military and civilian) involved in all facets of Primary Care. This course is designed to present a broad spectrum of material of direct pertinence to all physician assistants providing a substantial amount of primary care medicine in both a public and private setting.

LECTURE CONTENT
The primary focuses of this conference are Primary Care and Emergency Medicine. This is a Preliminary Schedule, although Speakers and Supporters are listed, They are Subject to Change without Notice. To assure the most up to date information available, the specific lecture subjects will be finalized and listed in the Final Conference Schedule and the SAPA web Site; www.sapa.org. This Preliminary Schedule lists the format of the classes.

CME
Between 30 to 35 hours of Category One CME will be applied for through the American Academy of Physician Assistants for the program conducted Monday through Friday.

SECURITY
The Board of Directors request that everyone secure their valuables at all times. Due to the behavior of a few individuals over several last years, name badges will be required for entry into all events. In addition to name badges, Security will be posted at the Exhibit Hall at all times it is open.

15th Annual Poster Contest
The Society will hold the Fifteenth Annual Poster Contest. All SAPA members are eligible to enter this contest. More information will be available at the SAPA web site, www.sapa.org

ACTIVITIES
1. "North Carolina Welcome Picnic"
2. “DJ Music”
3. “President's Reception”
4. “Evening Entertainment”
5. “Casino Night”
6. Karaoke Provided
7. Music Provided
8. “The 34th Annual SAPA Golf Tournament”
10. “Dance The Night Away With The Sounds of ‘‘” (Karaoke, Lip Sync, DJ Games, Assorted Music for Young and Old Timers)”
Society of Army Physician Assistants
Holiday Inn at I-95 Hotel and Convention Center Fayetteville, North Carolina 28309

34th Annual SAPA
PA Refresher Course

Apr 22nd - Apr 26th 2013

The “Best Bang for the Buck”

Tel: (309) 734-5446
Fax (309) 734-4489

send to:
SAPA Conference Registration
PO Box 623
Monmouth, IL 61462
In the following pages are articles from fellow PA’s, CPT Jolman and CPT Krauss, with various aspects to deployment medicine. Both PA’s have present different aspects to medicine within Afghanistan and share insights from their experiences. CPT Jolman just completed his deployment with the 17rd Airborne and CPT Krauss is starting his deployment with the 10th Mountain.

I hope that everyone enjoys their articles and this highlights one of my key points that will be covered later in Editors Notes. This is what to envision with this newsletter; to become a sort-of share point for all of us.
By CPT Scott R. Jolman, PA-C
Battalion PA, 1-503 (ABN)
173rd ABCT

It is no surprise that the War on Terrorism in Afghanistan is narrowing down, and the transition of security operations will be completely in the hands of the Afghanistan National Government, Afghan National Army (ANA), and Afghan Local Police (ALP) within the next couple years. Many challenges are and will continue to be faced in this transition. Within the political and operational side of the transition falls the transition of the International Security Assistant Forces (ISAF) role in providing medical coverage for the ANA, ALP, and Local Nationals. Governing this medical coverage is the Medical Rules of Eligibility (MEDROE) established by ISAF. MEDROE combined with the knowledge we possess on medical operations enable us to advise and assist the Government of Afghanistan into running their own medical operations.

MEDROE has already changed recently to complete medical coverage by the Afghanistan military and local medical facilities if possible and resources available. TF Eagle, 1-503 IN (ABN), operated out of Ghazni Province during OEF XIII and had the privilege of advising and assisting the Afghan National Civil Order of Police (ANCOP), Afghan Local Police (ALP), and Afghan National Army (ANA) in conducting their own medical operations.
The transition for TF Eagle began with a close working partnership with the SFAAT team co-located at FOB Warrior. Basic Combat Lifesaver Courses (BCLS) were put together in English and Pashtu along with class XIII (medical) supplies that could be obtained through the Afghanistan Inventory and Supply system. These classes were instructed by TF Eagle medics to a handful of ANCOP medics over a 4-6 week period. Training was conducted followed by a ‘certification’ practical exam much like what is experienced in the BCLS that is instructed to all our non-medical comrades.

Train the trainer concept was in mind when planning the road to success and it was quickly implemented when the first group of ANCOP medics trained was in charge of training their own organization on subsequent BCLS courses. TF Eagle medics supervised the blocks of instruction and assisted in the proctoring and grading of practical exercises. By the end out TF Eagle’s tour in OEF XIII, the ANCOP medics were able to perform and instruct all blocks of instruction on their own as well as provide classes to the ALP and ANA.

Simultaneously the Battalion Medical Operations Officer was advising, with the SFAAT team leader, the ANCOP team leader in basic medical operations such as medical evacuation, evacuation platforms, and patient care facility locations. Over roughly 6 months the ANCOP of Gelan district, Ghazni Province were able to plan and prepare for medical operations, effectively treat casualties sustained during operations, and evacuate them to local national medical facilities with minimal assistance of TF Eagle or the United States Armed Forces.

When US Armed Forces leave Afghanistan, the ANCOP, ALP and ANA will be forced to plan, execute and track their medical operations. TF Eagle achieved success in this mission through the excellent partnering of the Battalion with the ANCOP/ANA and SFAAT team. There is no doubt in my mind that the Afghanistan medical operations will continue to succeed and improve as US Armed Forces transition out of Afghanistan.
Holistic Care heads Down Range

By CPT Jeffrey C. Krauss, PA-C
Battalion PA, 1-87 (IN)
1BCT, 10th Mountain Division (LI)

FOB Arian, Afghanistan is home to an improved model in healthcare delivery in deployed settings – the 1-87 IN Resiliency Team. At its core, the team is comprised of the Physician Assistant, Battalion Chaplain, and the unit’s Master Resiliency Trainer, however, the team often includes additional ancillary services such as physical therapy, behavioral health, and dental services based upon Soldiers’ needs.

The team aims to provide Soldiers with comprehensive, holistic care delivered directly to the places where they live and work in remote areas. The team regularly circulates among all of the Forward Operating Bases that 1-87 IN Soldiers are assigned during their current mission in Afghanistan. In deployments past, Soldiers have had to travel, sometimes for several days, in order to access each of the services covered by the team. Such arrangements often resulted in lost man-power and disruption to the unit’s daily operations due to missing personnel. In some cases, Soldiers reported they avoided seeking needed specialty services because of the significant interference of obtaining such care, especially among leaders with responsibility for the daily management of many Soldiers. Over the past decade, the military has mobilized aspects of care to forward locations in response to this issue; however, such attempts have generally been limited to include only certain aspects of care, such as with the introduction of Combat and Operational Stress Control Teams. Our 1-87 Summit Resiliency Team aims to bridge this gap.

A benefit of the Resiliency Team model is that it allows for patient-centered care in deployed settings in that it provides Soldiers with increased options for healthcare decision-making according to their preferences. For example, a Soldier experiencing a combat stress reaction is empowered to pursue their preferred method of care such as peer counseling, formal behavioral health services, pastoral counseling, or medical consultation. Similarly, Soldiers can work with team members to develop a comprehensive approach to care should they wish to include several aspects. Since the team works as a
unit, providers are better able to create holistic treatment plans that address many aspects of wellness and are guided by the patient’s intent.

Speaking on the topic of the Resiliency Team of which he is a member, 1-87 IN Chaplain CPT Michael Spalla noted, “As a chaplain, I see that my ministry to soldiers often links hands with other disciplines, specifically the physician assistant and resiliency trainer within my own battalion. The creation of a resiliency team allows us to intentionally use our respective training to nurture the whole person in body, mind, and spirit.” In addition to the delivery of direct services to Soldiers across the operating environment, the Resiliency Team has the additional ability to consistently monitor the general wellness of the force over the length of the deployment as evaluated from multiple professional perspectives. Such assessments allow the team to respond to changing needs among Soldiers in a timely, flexible manner that is driven by the Soldiers themselves.

*From left to right:* CPT Krauss 1-87 IN BN PA; SSG Reyes BN Master Resiliency Trainer; CPT Spalla BN Chaplain; PFC Dwight BN Chaplain Assistant.

CPT Krauss is currently deployed to Afghanistan in support of Operation Enduring Freedom
The 1-87 IN Resiliency Team echoes a general shift to the Patient Centered Medical Home model currently underway in Army garrison environments. Similar to that model, Soldiers are recognized as important members of the healthcare team collectively focused on pooling resources and knowledge to produce the best outcomes. Another similarity is the Resiliency Team’s ability to engage Soldiers before issues develop, allowing for the establishment of trusting relationships, delivery of preventative services, and reinforcement of positive wellness practices in which the Soldier already engages. Like the Patient Centered Medical Home model, the 1-87 IN Resiliency Team focuses on face-to-face, personalized delivery of care that is inclusive of as many wellness components as the Soldier prefers. In addition, Soldiers can determine the make-up of each contact for services whether it be individual consultation with one team member or a group appointment where all parties focus on meeting the identified need.

Although limitations exist, such as barriers to travel and operational constraints, the 1-87 IN Resiliency Team aims to provide the highest quality healthcare experience possible to deployed Soldiers. 1-87 IN Battalion Commander, LTC Daniel Morgan, stated, “My Resiliency team circulates the battlefield more than any other force, and that is what makes us great.” Given the fact that many currently deployed Soldiers have previously deployed, multiple times in some cases, regularly available comprehensive services focused on maintaining overall wellness is a force multiplier.
EDITOR’s NOTES

Fellow PA’s,

First I would like to thank MAJ Detro and the SAPA community for giving me the opportunity to help serve all of you as the new editor for the SAPA Journal; I hope to not disappoint anyone.

Next I would like to apologize to all for the delay of this current journal. It was not my intentions to have such a large gap between editions, but with a recent PCS move, Pre-Deployment events, and currently deployed; things have fallen thru the cracks.

My goals are to make this a fun and informative journal that all of us can enjoy; a sort-of platform for our Society, which brings me to my first point.

When I step back and look at our name, Society of Army Physician Assistants, I want to embrace that word: Society; we are a proud family. I feel that we need to depend on each other in order to move forward. I feel that we are a iron triangle. Each pillar is iron beam; alone the iron is just a beam, but when they are placed in a way, each pillar supports each other and builds and maintains a solid object.
Each pillar is represented by the following: the Present, the Past, and the Future. The Present represents our current active duty PA’s. The Past (not to be derogatory) represents our retired PA’s that are still active not only in our community, but in their represented civilian community. Finally the Future represents the students that are currently in IPAP. I feel that in order to move forward, we need to look back at where we have been and concentrate on the horizon in front of us.

I want to embrace this Iron Triangle and utilize this Journal for all pillars. My goals are that each pillar will have a section within the SAPA journal so that we all know what we are all doing.

This leads me into my second point/goal: our Circle. Within our close-knit community, we have different threads of cloth that make up our society. Even though we are all PA’s within the Army, we all represent different aspects to the units we support. We represent the Conventional Forces (CF), the Special Operations Forces (SOF), Aviation, the National Guard/Reserve, and HRC. I feel that we all must help each other regardless of where we come from. Each unit has information that can be shared for the greater
good of the entire group. I would like to envision that each thread have a space within the Journal to help with the flow of information.

Finally my 3rd point/goal is to have a section within the Journal dedicated to various posts, both CONUS and OCONUS. As I have learned when I arrived to Fort Drum, NY each post is slightly different and handles common situations differently, i.e. no dedicated military hospital and dependent on the local health care for certain consultations. I would like to utilize the Journal as spotlight for each post. This will allow the Division PA’s to highlight their posts and show the rest of the PA community their little niche that they call home. I am unsure how the rotation would be, but I will be calling and asking for help with this one.

Well I will wrap this up and let everyone get on with their business. Again I thank all of you for your support and I hope to continue the growth of the Journal that MAJ Detro has started.

Thank very much,

v/r

Chris

1LT Mueller is currently deployed to Afghanistan in support of Operation Enduring Freedom with the 10th Mountain.
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**SUBMISSIONS**

The SAPA Journal staff and SAPA Board of Directors encourages membership participation in this publication.

Feel free to use this forum to present your views on any topic you desire. The publication of clinical articles on any subject is also solicited, however, to reduce our workload, we do request articles be presented typed, double-spaced format, and on CD, Microsoft Word format.

The editor reserves the right of final acceptance of articles as well as the right to serialize articles which are too lengthy to be included in a single issue.

Articles will be accepted via email.