



SOCIETY OF USAF FLIGHT SURGEONS
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Vol. 32, No. 3, Summer 2019

Words from the Wise

President's Column

Duncan "SLASH" Hughes, Col, USAF, MC, CFS
President, Society of U.S. Air Force Flight Surgeons



Hello! Let me start by saying a big "thank you!" to all of you for the trust and confidence you've wagered in selecting me as the new president of SoUSAFFS. Way to make a guy feel old! Well, from my perspective, all of the previous presidents were old folks! Am I wrong? Guess that's now the pot talking to the kettle...but, again, thanks (I think!).

What an exciting time to be serving as a flight surgeon in the USAF! We've got just a wee bit of change afoot. I recently heard it stated that we've got a 30-year-career's worth of change happening in the AFMS in a 12- to 18-month window. Pick a topic: DHA transition, OMRS transition, AMRO boards, 95% readiness goals, MHS Genesis, planning for trusted care in peer-peer adversary engagement scenarios, exploding numbers of integrated operational support platforms, etc., etc., etc. Meanwhile, the daily privilege of supporting the mission and caring for our aviators and operators continues unimpeded by any of this tumult. It has been my experience, as a self-declared "old guy" with maybe a lap or two around these blocks, that it is easy to let such chaotic environs become a distraction sapping our energy and focus away from our *raison d'être* (reason for being): 1) supporting the flyer/operator, 2) providing trusted care in any scenario, and 3) taking care of one another. If I could encourage you to do just one thing, it would be to focus your energies and passions not on the former list of the chaotic changes, but rather on the underlined items that won't change no matter the governance structure in place or the IT system crash-of-the-week. When you're ensuring the mission, providing outstanding care, and looking out for one another, all of those other things will reside in the periphery. While I lived through Optimizing Primary Care and PCMH, etc., those programs came and went and are not what I'll remember about those years. What I'll take with me are the successful missions, the lives saved, and the lifelong friendships. Keep your focus on our *raison d'être* and you'll excel while the distractions ebb and flow!

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So, what does it take to excel at our *raison d'être*? Education, training, currency, and proficiency! In this issue of *FlightLines*, you'll find some important updates about education and training opportunities in our career field. I'd encourage you to take full advantage of these opportunities! One of the most common refrains I've heard over the years regarding the decision not to pursue aerospace medicine as a specialty is that it won't translate into career opportunities in "life after the Air Force." I am here to tell you definitively that such an opinion is wholly uninformed! The lessons learned from our comrades recently promoted to civilian life reveal exactly the opposite! The demand for your skill set (i.e., someone educated, trained, current, and proficient in primary care, aerospace medicine, and occupational medicine) is insatiable. So, take advantage of the myriad educational, training, and experiential opportunities that being a USAF FS affords you – they will place you on exceptional footing both during and after your AF career! 🍀

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From the Editor

Mitch "NACHO" Radigan, Maj, USAF, MC, FS
 RAM XX

I am grateful for the privilege to be part of this editorial team. It is amazing to learn from each of you about your adventures, trials, trips, and advice. I love the diversity of aerospace medicine and the abundant opportunities to make a difference for the warfighter.

I am amazed and honored by the opportunity to serve as a flight surgeon. I recently visited Arlington National Cemetery with my family. It has been 25 years since my last visit, and my reverence and respect for the individuals there have greatly increased. The rows of hundreds of thousands of honorable men and women who have given so much for us are breathtaking. We truly stand on the shoulders of greatness. I'm certain that many of them would not say that the part they played was anything great and that they were just doing their job. I believe that is what we have to do as well: be prepared, show up, and do the job. What sets us apart from the rest of the country is that we have volunteered to show up. When the unknown strikes, what makes us great is holding our ground and doing our job.

Education is the foundation for our success in doing the job. No matter what organizational changes you are facing, knowing how to think operationally and how to be a physician are key. This newsletter highlights some core educational opportunities for serving as a USAF flight surgeon, expanding your knowledge, and some of the history behind it. I hope this encourages you to seek opportunities to master your craft and to mentor more junior and future flight surgeons. 🙏



FlightLines: Vision and Mission

Our vision: FlightLines is the written forum for the Society of United States Air Force Flight Surgeons. We help facilitate top-to-bottom, bottom-to-top, and horizontal dialogue within the Flight Surgeon community.

Our mission: We provide a vehicle to pass the vector and tools to Flight Surgeons so they can do their jobs effectively and efficiently as current and future leaders within Team Aerospace.

Off We Go!

Paul “METRO” Vu, Maj, USAF, MC, FS
RAM XIX



I hope FlightLines has been as interesting for you to read as it was for me to edit. Thanks to the many writers who contributed over the past 2 years. I hope you continue to share your wisdom and insight. As I hand over executive control to Mitch Radigan, I'm certain he'll take the newsletter to greater heights.

As we move on to our next challenges, I ask for us to all watch out for one another. Let's help reduce the uncertainties by setting a low threshold for reaching out to each other when confronted with the daily crazy-makers. The following is a list of names and future assignments for everyone's SA. Fly safe my brothers and sisters. 🛩️

Call for Content

What makes FlightLines great is that it connects us with the rapid changes and variety of expertise that exist in USAF flight medicine. Send us news that affects us all, teach us about your area of expertise, and share with us your “There I was...” stories from the field. (Include your pictures!)

Submission guidelines:
500-3000 words
Pictures 300 dpi or better in .tif or .jpg

Send your articles, news, suggestions, or comments to:

mitchell.radigan.1@us.af.mil

Moving, need your FlightLines sent to another email address? For FlightLines distribution/email update, please contact the Executive Editor, mitchell.radigan.1@us.af.mil.



SoUSAFFS Membership

To update your society membership or contact information, please visit www.sousaffs.org, login, and select “Edit Profile.” Your dues can be paid by PayPal. For any questions or concerns regarding your membership, please contact Lt Col Stefanie “Phantom” Watkins Nance at membership@sousaffs.org.

SoUSAFFS 2019 Award Winners

AsMA is a great place to catch up with colleagues, learn something new, and celebrate those who exemplify what it means to be an Aerospace Medicine Professional. Please congratulate this year's SoUSAFFS award winners for their outstanding contributions.

- Malcolm C. Grow Award: Capt Jean-Gabriel Coignet (AFSOC)
- Operational Flight Surgeon Safety Award: Capt Brittney Dudley (PACAF)
- Team Aerospace Award: 325th AMDS – Tyndall AFB (ACC)
- Olson-Wegner Award Airman: SrA Cheree Voto (AMC)
- Olson-Wegner Award NCO: TSgt Richard Reed Graham (AFSOC)
- Olson-Wegner Award SNCO: MSgt Nicholas Grahams (AFSOC)
- George E. Schafer Award: Col Bryan Funke

Help SoUSAFFS Grow!

Flight Surgeons, have you joined SoUSAFFS yet? The Society of Air Force Flight Surgeons is a constituent organization of AsMA that more specifically supports the needs of AF Flight Docs, with a focus on education, mentoring, and networking. We are reaching out to our cadre of young physicians to make our organization one that is essential to be a part of. Not only will SoUSAFFS membership afford you invaluable networking opportunities, but it will also make you eligible for retreats/trips to other bases to experience other missions/airframes and bond with your fellow Flight Docs! We want to grow our organization, and we can't do that without bright ideas from excited young docs! Join us today at www.sousaffs.org.

For more information, please contact Capt Brooke Organ at brooke.organ.1@us.af.mil.

Around the Air Force

In Case You Missed It...

David “BANJO” Navel, Lt Col, USAF, MC, FS
Chief, Aerospace Medicine, Hurlburt Field, FL

The Unhealthy Truth

Sitting in a recent Commander’s Call, our Group Commander was visibly shocked as he recalled what he and other commanders had recently been told at a conference: 71% of men and women age 17-24 are unable to meet the physical standards to join the Armed Forces.¹ As flight medicine physicians, a lot of the preventive measures fall to us to help the base and community populations as best we can. In light of this, it’s worth pointing out other recent publications. First, Americans are sitting more. On average, we sit approximately 1 hour more per day than we did 10 years ago, and that number is higher in our adolescent population.² Second, one in five kids report drinking no water during the day.³ None. Combined with low activity, it’s no wonder many people fail to meet military standards. Our part in this is important. Reviewing the American Academy of Pediatrics recommendations for lowering sugary beverage consumption, hospitals and medical providers play a key role in encouraging water and milk consumption over other sugary drinks.⁴ Also, there are new guidelines for the primary prevention of cardiovascular disease that emphasize lifestyle modification among recommendations on treating hypertension and abnormal lipids.⁵ Go save lives!

Space Herpes

Now that I have your attention, please know that approximately half of all astronauts shed at least one type of herpes during their travels.⁶ While this may seem like a nifty factoid of limited relevance, it brings to mind questions about future immunocompromised or pregnant passengers.

Other Honorable Mentions

The U.S. Preventive Services Task Force has drafted a statement to add to its 2013 Grade B recommendation for interventions on youth smoking to now include electronic nicotine delivery systems.⁷ The Grade B is for preventing initiation of tobacco use. They offer a Grade I for insufficient evidence on the feasibility of cessation programs in that age group. In other news, San Francisco, the corporate home of Juul Labs, has gone so far as to ban e-cigarettes.⁸ 🚬

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Aircraft Automation

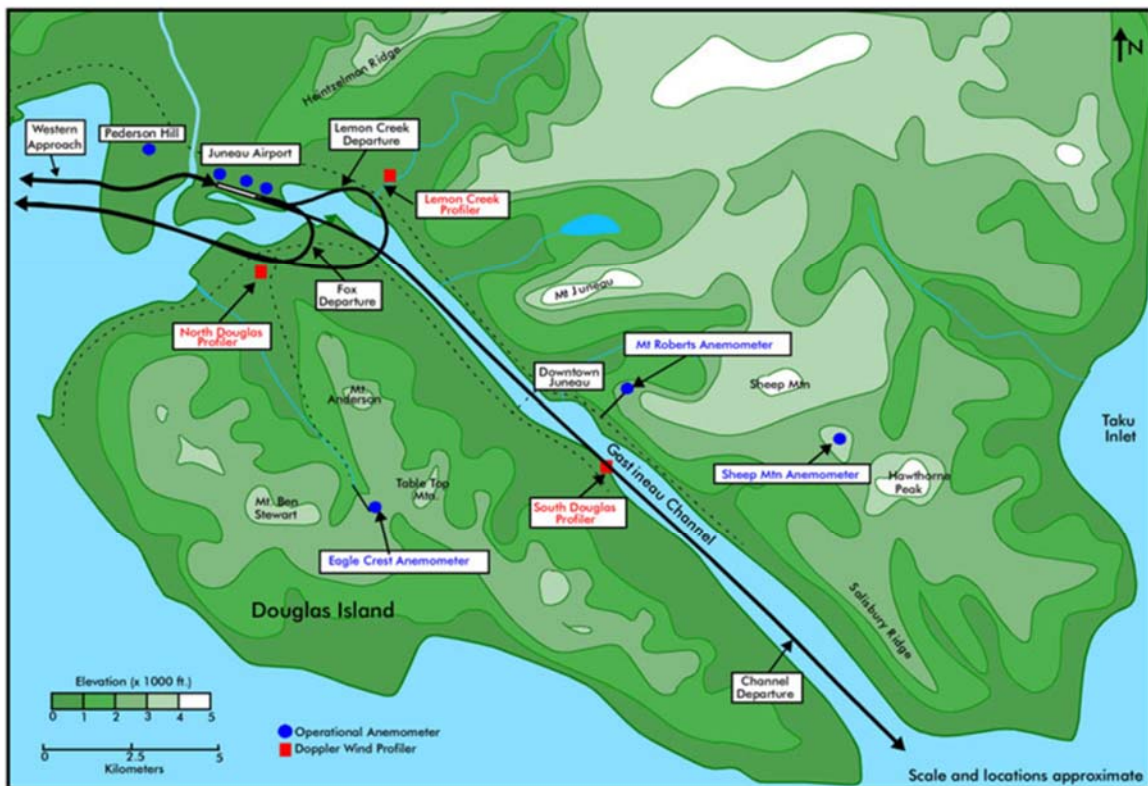
David “BANJO” Navel, Lt Col, USAF, MC, FS
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Scenario One

Flight ET302 took off at 08:38 in the morning. Six minutes later, it crashed with enough force to bury both engines 10 meters below the surrounding level ground.¹ Similar to the fatal Lion Air flight in October 2018, an automated safety system known as the Maneuvering Characteristics Augmentation System (MCAS) is blamed. When the angle-of-attack sensors indicate that the nose is elevated, the MCAS lowers the nose to prevent a stall. When a sensor is wrong, the MCAS pushes the nose to the ground. The system can be disabled, but only temporarily. If false readings continue, the system automatically turns itself back on every 5 seconds and continues to lower the nose. Turning the MCAS off completely at the CUT OUT switch means manually turning the trim wheel to elevate the nose, a difficult task made harder when the aircraft’s attitude is already askew. The accident claimed 157 lives.

Scenario Two

A herd of residents descends on the Federal Aviation Administration in early December, eager to learn and perhaps, for some, secure future employment. On hand are experts in the field of human-machine interfaces running a myriad of complicated and realistic moving simulators. One of the Canadian cohort sits in the pilot seat of a Boeing 737 taking off from Juneau International Airport. The layout of the cockpit is accurate except for a fire extinguisher tucked behind my seat. Outside our windows, fog covers everything. Visibility isn’t so much an issue as it is an impossibility. The instructor advises our fearless pilot (it was a simulator, after all) to follow guidelines and trust the computer. In a few moments, we take off blindly, turn nearly 180 degrees, and maintain our climb out of the area. If the weather had permitted, we could have counted the needles on each of the pine trees below. As it was, the computer projected a three-dimensional map of the terrain below us, turning our flight screen into something out of Tron. As we circled Douglas Island and began our approach through the tiny southeastern valley, the weather magically improved. The configured computer mapping gave way to actual mountains and hills looming over us. Our wings seemed too close for comfort on either side as we dropped closer and closer to the waters of Gastineau Channel below. Eventually, we made the final turn and completed a perfectly “safe” landing, which if not for our Oklahoma surroundings would be just one of the 298 operations that actually happen at Juneau International Airport every day. Our instructor remarked that this was only possible because of the wonders of technology. Computers had now turned nearly impossible conditions at an already difficult airport into something a student pilot could easily master. This same terrain had claimed the lives of 111 people in 1971, fueling the curious in us to ask if technology now could have prevented this.



Map of the Juneau Airport Wind System showing some of the flight patterns. Available at www.weather.gov/images/ajk/jaws.jpg.

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Our instructor points out that approaches and clearances are now possible that human error would never have allowed. I nod – after all, I just successfully landed an Airbus A380 at San Francisco International Airport with no guidance other than to point at the runway and not miss. The automated systems made this far too easy, and the upcoming ACAS X system may allow multiple planes to do this on parallel approaches too close to consider with current technology by “dynamically adapting future U.S. airspace to traffic.”² But with a computer that barely needs me in the seat, I can’t help but wonder how I would fare when that machine relays wrong information. All this time flight medicine has rested its laurels on having nearly perfected the risk mitigation of humans in flight only to have this achievement erased in lines of code and whirring hard drives.

So where do we draw the line? There are so many disparate opinions from science fiction horrors to utopian futures that it’s difficult to see clearly what we face as aeromedical experts. Progress is coming, and we owe it to the public to balance what we maintain is safe with what we deem relevant to the future of travel. Perhaps improved automation will eliminate the need for certain flight patterns. Just maybe a computer can read the lift and metrics of individual panels to better balance the aircraft and control it through turbulence. Our future in flying may play out like a midnight infomercial: faster, smoother, easier, and hassle free. Regardless, the human interface in the design of these systems deserves closer inspection for the population we serve. We need automation if we are to move to a future with more passengers and more aircraft, yet we need systems that eliminate the variations of human error but not the humans themselves. As we look to the future, I encourage all of us to recognize our unique roles in making this all a possibility. We cannot neglect technology or how aircrew must cope with it. 🙌

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Welcome the RAM XXI Class

The Residency in Aerospace Medicine is a great training program that helps grow current and future leaders in the USAF. It builds our community and the relationships that help us get the job done and the warfighter safe and healthy. Please welcome the latest herd undergoing RAMification! 🐏

Resident	Medical Degree	Specialty	Prior Duty Station	MPH	Call Sign
Lt Col Kevin D. Alford	MD	Internal Medicine	Wright-Patterson AFB	Harvard	
Lt Col Michael W. Crowder	MD	Emergency Medicine	Hickam AFB	Wright State	Cobra
Capt Maxwell Dickey	MD	GMO	Randolph AFB	UC Berkeley	Trickey
Lt Col Clayton J. Rabens	MD	Family Medicine	Data Masked	Harvard	Stu
Lt Col Stephanie E. Wilson	MD	Pediatrics	Dobbins ARB	Mercer	



The Next Chapter in Aeromedical Education – from the AMP Daddy

Bryant “Thunda” Martin, Lt Col, USAF, MC, CFS
Chief, Aerospace Medicine Education Branch

Since the term “flight surgeon” was coined at Hazelhurst Laboratory on March 11, 1918, and the first three physicians graduated, flight surgeons have been the widget called upon in times of crisis and change. As my AMP Daddy would readily say of the flight surgeon, “Break glass in case of war.” As the field of medicine grows and the expectation of the U.S. Air Force for excellence continues, the role of the flight surgeon continues to expand to meet the demand. Today, the battle call is one for readiness. Hearing that call, USAFSAM has been working feverishly to meet that demand.

Maj Louis H. Bauer took over flight surgeon training in 1919 and established the first permanent course of instruction as a 2-month-long training curriculum at Mitchel Field, Long Island. The Medical Research Laboratory and School for Flight Surgeons has continually produced the world’s foremost flight surgeons ready to serve and protect those in harm’s way. Over the last 100 years, the school’s name has changed, the location has changed, the people have changed. What hasn’t changed is the dedication to excellence and the desire to continually evolve the educational process, ensuring that our flight surgeons have the best training available as they go forth to serve our Airmen. With that in mind, we are very proud to introduce the newly minted 2-month-long Aerospace Medicine Primary (AMP) course that will be kicking off with the spring 2020 courses.

For those unfamiliar with the current process (or old enough like me to remember the days of a single direct AMP course), let me summarize how it has been. AMP has been broken up into four courses of 2-3 weeks duration known as AMP 101, 201, 202, and 301. Five years ago, the then Surgeon General of the USAF directed all medical students to attend AMP 101. This policy change had a direct impact on what could feasibly be taught in this course, as the now majority of the students do not ever go on to serve as flight surgeons. AMP 301 has been problematic, as it occurs after graduation and its intent has been multipurposed and evolving over the years.

Going forward, AMP will continue to be a four-course process, with each iteration being 2 weeks long. The major change will be dropping AMP 301 and replacing it with a new pre-graduation 2-week course. The first two courses in the series have been renamed Air Force Operational Medicine (AFOM) 101 and 102 and will replace AMP 101. The final two courses retain the name Aerospace Medicine Primary 201 and 202. For now, these four courses will serve as the core curriculum for flight medicine providers to the USAF. As you can surmise by the name change, the Aerospace Medicine Education Branch and USAFSAM are positioning themselves for potential growth and changes, with developments being seen in the Operational Medicine Readiness Squadrons and the newly termed Warfighter Operational Medicine Clinics. Let’s take a moment and break down each course, and you’ll begin to better understand the vision of how we believe this new curriculum will match the demand signal.

AFOM 101: INTRODUCTION TO USAF MEDICINE (2 weeks)

AFOM 101 is the evolution of the previous AMP 101 course with the emphasis built around introducing the new provider to the role of the medical provider in the Air Force Medical Service (AFMS) and the role of the AFMS in the USAF. The intent is to educate newly minted medical officers in the dynamic world they are now an integral part of and introduce them to a different thought process foreign to most of our training. The course focuses on the many capabilities of the USAF and how the medical missions within those areas differ. The students will be introduced to new concepts such as a broad overview of the aeromedical evacuation platform and capabilities, physiological aspect of continuous operations, concept of occupational and preventive medicine in light of force sustainment, and aviation fundamentals, to mention a few. The students will continue to spend a day at the local airport being introduced to aviation and experiencing small aircraft flight. This course will continue to serve as an introduction to medical students and be the first course in the pipeline for flight surgeon training.

AFOM 102: CLINICAL OPERATIONAL MEDICINE (2 weeks)

AFOM 102 is technically the new course in the series, but is so by name only. The majority of the curriculum has been reshuffled from AMP 101 and AMP 201 to form this course. The intent of this course is to provide the building block for a competent occupational primary care provider for the Air Force – someone who can actually function in a primary care clinic for active duty service members. To train flight surgeons all these years, we’ve had to be proficient on all skills that now fall under the BOMC umbrella. We’ve always taught special exams, MEB/IDES, profiling, SHPE, and so on. These are skills that we have taught and have been expected to master in the field. AFOM 102 brings all of these non-aviation, Air Force occupational skills under one course. As we looked at what skills also made us competent occupational providers for the Air Force that weren’t aviation-based, we found additional items. Many of the concepts in occupational medicine found in AMP 201 and the Occupational Medicine Symposium have been built in such as shop visits, special exams, fitness for duty determination, arming use of force, and PRP. AFOM 102 includes blocks of instruction designed to teach a clinician how to prepare a patient to enter the aeromedical evacuation system. In other words, if a provider was to be at an EMEDS, what could he or she do to better understand the process of AE and how could he or she prepare the patient medically so the handoff to the clearing flight surgeon is that much smoother for the patient and the AE team? Additionally, if a mass casualty were to occur on base such as a bus accident, it would be all hands on deck for response. AFOM 102 includes a block of instruction introducing disaster response, the Incident Command System, and concepts of working with the local EMS. The 2-day medical response to CBRN training previously found in AMP 301 has been incorporated here.

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AMP 201: ADVANCED CLINICAL AEROSPACE MEDICINE (2 weeks)

AMP 201 has been the bread and butter course for teaching clinical competency for flight medicine since its inception. The problem – there hasn't been enough time to meet the stated goal. With this new curriculum model and the movement of the non-aviation material to AFOM 102, the table has been cleared for a conceptionally different approach. Throw out what you remember of AMP, the big lecture hall, the long hours of Charlie Brown's teacher. We promise better. AMP 201 is limited to a class size of 36 students. Each class will be organized into 6 flights (flight Ellsworth, flight Eglin, etc.) of 6 students. Each student will be given a case study on day one such that each member of each flight will have one of the six different case studies. The goal is for each baby flight surgeon to carry his or her Airman through his or her entire career from initial flying class physical to SHPE with every bump along the way, be it deployment, waiver, toxic exposure, etc. The course is designed to only include a few hours of lecture each day, with the remaining time divided between laboratory time and small group work. An example of a typical day is as follows. In the morning all students would receive 2 hours of lectures on AFI 48-123 and the Medical Standards Directory to thoroughly understand their purpose and function. During the remaining 2 hours of the morning, each baby flight surgeon from the six flights with the same case study will meet to work through the scenario given that day. In other words, all six flight docs from the six different flights assigned TSgt Snuffy as their case study on day one will meet to discuss the new scenario: TSgt Snuffy is trying to become an aerial gunner who happens to have poor depth perception and is seeking a waiver for an initial flying class physical. Once the team comes to a working solution, they will have the opportunity later in the day to reconvene with their own flight and present their case while listening to the other five members present theirs. Sound familiar? Hopefully, you've been attending your FOMWG meetings! The power of this approach is that members must use the resources available to search for the answers, the process is designed to demonstrate all the parts of flight medicine in a sequential manner, and the FOMWG reinforces normal clinical practice while introducing breadth of experience.

Interspersed throughout the AMP 201 experience is a myriad of additional learning opportunities independent of the case study. The course will kick off with hypobaric chamber training previously held in AMP 202. It will also include the reintroduction of aircrew life support equipment familiarization and aircrew meals! The new AMP curriculum is built on the concept of drawing a continuous development model from course to course. Aeromedical evacuation training is a perfect example of this. AFOM 101 introduces the student to the USAF capability of AE. AFOM 102 teaches the provider how to prep a patient for AE more efficiently. The plan for AMP 201 is to train all flight surgeons to be competent clearing flight surgeons and meet Air Mobility Command's expectations for deployment readiness. Working with TRANSCOM, we are incorporating training from the Advanced Clinical Concept in Aeromedical Evacuation Symposium and the Clearing Flight Surgeon's Handbook.

AMP 201 will continue to include in-depth discussion on aviation physiology from our experts at the Aeromedical Consult Service. The spatial disorientation trainer previously taught in AMP 101 has been moved to this course and the education section consolidated to include human factors and the reintroduction to Initial Safety Board response. Needless to say, AMP 201 is really the "new" course in the flight surgeon pipeline and the one we're most excited to introduce.

AMP 202: AEROMEDICAL AVIATION LABORATORY (2 weeks)

AMP 202 has been the capstone experience for flight surgeon training since it began when USAFSAM moved to Wright-Patterson Air Force Base. It will continue to be so and will continue to improve. The course is a collaborative effort with Greene County Airport and MacAir. The students will start the course with the physiologist and complete their centrifuge training during the first 2 days before transitioning to Greene County. The remaining 8 days will be dedicated to a brief ground school and safety training followed by a series of eight flights. Each flight is designed to introduce the baby flight surgeon to a different aeromedical aspect of aviation. Six of the flights are completed in the Cirrus aircraft, one in a high-performance acrobatic aircraft, and one in a private helicopter. The entire experience from the day they enter to the moment they leave has been scripted to resemble that of an active duty fighter squadron. All of the pilot instructors selected to teach the course are retired generals, graduated wing commanders or group commanders, with tens of thousands of hours between them. Each day is conducted with squadron briefings. The students are expected to memorize Bold Faces of which they must pass written tests and can be called upon to present orally as emergency procedures of the day at any time. Each flight ends with a pilot-student debrief to review the flight. DO NOT BE MISTAKEN. We are not training pilots and that is not the intent of this course. Each flight is designed to introduce an aeromedical concept. What would it be like to have a physician determine driving privileges on a patient when the physician doesn't drive? We know the argument! We make the argument. Why does a flight surgeon fly? Each flight and each debrief is followed by an aeromedical decision-making case study. Our senior-most flight surgeons attend each day, ready to catch each baby flight surgeon and conduct their own debrief. For an hour or so the students work through case studies based around the aviation principle they just experienced in flight. For example, after flying a 1.2-hour sortie in a two-ship Cirrus formation and being wing tip to wing tip, the students and the USAFSAM flight surgeon discuss visual acuity, depth perception, and visual fields and review case studies and the impact of waivers for certain airframes vs. other airframes.

In addition to the debriefs, there are a number of refresher aeromedical briefs included during the ground training and safety briefings designed to reinforce the concepts introduced in previous AMP courses. The new curriculum plans to leave AMP 202 wholly intact, but promises to continually improve the case studies and tighten up the learning process.

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THE FATE OF AMP 301

The current version of AMP 301 has been a bundling of previously individual courses. Going forward the following will occur:

- 1) Aircraft Mishap Investigation Primary course will return to its prior status as a stand-alone course that will be offered twice annually in the spring and fall.
- 2) ATLS will continue to be offered immediately following the conclusion of AMP 202 and will be open to all registrants with priority to pipeline AMP students.
- 3) CBRN training has been included in AFOM 102.
- 4) Centrifuge training has been included in AMP 202.

WHAT HAPPENED TO THE SGP SYMPOSIUM?

As you may have noticed, we pulled the SGP Symposium offline a few years back, as it had become a bit long in the tooth and was due for some revitalization. This past spring the new course was launched, and feedback from the end-of-course evaluations was off the charts in support of the new direction. The schoolhouse asked us to take the course in a different direction and, in doing so, asked for a new name to come along. AOMED, or the course formerly known as the SGP Symposium, stands for Aerospace and Operational Medicine Executive Development (not my first title choice but it was the one that survives Public Affairs scrutiny). The name change leaves the door open for the course to someday include the presence of senior flight and operational medical technicians who work side by side with the SGP to deliver on the six programs of the Aeromedical and Operational Enterprise.

The course is 5 days long and is structured around two blocks of education. The first 2 days focus on career and professional development to prepare an individual for the role of an SGP. It explains the key concepts and interactions of the enterprise and how to deliver the products the line of the Air Force demands. The first block lays out expectations for the SGP from the different community members, such as wing commanders, emergency response personnel, hospital commanders. It also aids the SGP in understanding the top-down approach to the AOME by gaining a larger perspective regarding emerging topics from the AFMS and core mission programs.

The final block of instructions breaks down the six core programs of the AOME as outlined in 48-101 that the SGP is responsible to deliver to the med group commander via the Aeromedical Council (AMC). Each program is seen from an oversight perspective and then detailed to the significant players and products that work together to deliver the final report. Finally, each program is discussed based on the intended final product or report that must be generated to fulfill the AMC requirements. The intent is for each participant to leave with a clear sense of the breadth of responsibility placed on the SGP as a starting point and with tools to begin to tackle the assignment. The class concludes with round-robin sessions on topics that are too brief to need a full lecture but serve as quick primers or reminders for the new SGP – how to complete a COHERS, what is the science behind the audiology exam and interpretation, what are the appropriate action steps for dealing with a confirmed HIV positive lab result, etc.

The course will be offered twice annually in September and April of each year and is intended for those who have met the SGP selection board, just arrived as a new SGP, and realized somewhere along the way as an SGP that they still have no clue as to what they're doing.

CONCLUSION

As you can tell, this is a major undertaking by a small but dedicated group of staff who are committed to the continued delivery of excellent flight surgeons. As with every aspect of our military life, change is in the air. While the drive to produce is forever at our back pushing harder each day, the resources seem to vanish as mysteriously as my youth and good looks. That said, we are focused on building the next level of this house started 101 years ago by the ancestors who left us this charge, “Volanti Subvenimus.” You support the flyer and we support you! 🍷

USAFSAM RAM – Update

David “Dirty” Miller, Lt Col, USAF, MC, SFS
RAM Program Director

Many of the rumors you have heard have a kernel of truth to them, unless it involves the RAM. In that case, the 10% rule is an exaggeration. The USAFSAM RAM has received a great deal of interest and scrutiny over the last several months that has identified areas for improvement in the program administration and curriculum that will result in a stronger program for all residents. These changes will serve to advance the state of the USAF flight surgeons as well as the entire specialty. (In other words, yes, we are in compliance with ACGME, ABPM, ACPM and we are raising the bar. Also true – we have RAMs incoming from the FAM-RAM this year, but no new RAMs from the field starting their MPH, long story.)

The primary purpose of the Residency in Aerospace Medicine is to prepare physicians for board certification in the specialty of aerospace medicine in accordance with the requirements established by the American Board of Preventive Medicine (ABPM) and Accreditation Council for Graduate Medical Education (ACGME). In accordance with the ABPM and ACGME, the RAM program is a 24-month curriculum that includes an academic year and a practicum year. During each of those training years, the residents will complete at least 16 weeks of clinical training, as well as ABPM, ACGME, or USAF required training courses or rotations. Also, graduate-level scholarly work is required for the residency in addition to the final papers and presentations required during the academic year. As of July 2019, the ACGME has become more directive and specific about the aviation requirements for aerospace medicine programs, so the USAFSAM RAM is enhancing the curriculum and operational flying requirements accordingly. (In other words, we are training docs to be specialists with legit requirements, including HOTAS. Also true – 24 months is 2 years, not more. Maybe less if you have experience and an MPH/MOH already.)

This year, the Health Professions Educational Requirements Board authorized USAFSAM RAM for a total of 30 residency positions (15 per year x 2 years). This includes a new authorization for 2 highly qualified applicants to apply for the University of Texas Medical Branch – Galveston program, which is closely aligned with NASA. Applications for the new RAM programs are currently under review in MODS in coordination with our other services’ aerospace medicine programs. Highly qualified graduate medical officers (GMOs) with the requisite experience and training may apply and will complete their MPH at Wright State University. (GMO applicants must have successfully completed an internship with at least 10 months of direct patient care, passed steps 1-3 of national licensing examinations with clinical skills portion, and successfully served 2 years as a flight surgeon with a duty AFSC of 48X.) In some cases, exceptionally qualified applicants with a previous primary care board certification may request approval for an MPH/MOH at another location and would only spend 1 year at WPAFB to complete the practicum year. At this time, the AFMS does not support sending colonels, or colonel-selects, to any residency. (In other words, GMOs are back! Also true – Wright State University has a sweet program set up for us, and the more folks we have in that program, the more we can “influence” it.)

The training requirements placed on the RAM ensure broad exposure to unique and demanding fields of study, which enables aerospace medicine specialists to excel in a plethora of positions. RAM graduates have historically served in a vast array of roles maximizing aerospace and operational medicine program productivity in resource-constrained systems and optimizing warfighter performance in non-permissive environments with challenging mission sets. The diverse experiences and specialized training of the Residency in Aerospace Medicine enables RAM graduates to provide full-spectrum care for their patient – the base as a population and the aviator/operator as an individual. (In other words, own the specialty. This is an amazing opportunity for a board certification and unique experiences that will open doors for you in the “real world” . . . wherever that is.)

TL;DR version: RAM is getting gooder. If this is the only line you read, it isn’t the program for you. 🍷

That First Salute

**Preston “Cuffs” Laslie, Lt Col, USAF, MC, SFS
Commander, 52d Aerospace Medicine Squadron**

Day Zero

It’s kind of like getting married.

Someone stands at a podium and says a bunch of things. You barely notice because your knees are wobbly. There’s a knot in your throat and another in your gut. It’s formal. Pomp and circumstance like in the movies. A squadron of Airmen ironed their dress blues and proudly stood for a uniform inspection before the big occasion. It’s an unseasonably hot July 1st in Germany at 95 degrees, and I swear it’s 195 degrees underneath this blue jacket...195 Celsius. There’s no air conditioning in most buildings at Spangdahlem, and the famous “Brick House” I’m finding is no different.

The narrator continues. “Please rise for arrival of the official party.” That’s us, I think. In we go...off on the left foot, marching up to the front in single file, trying not to trip while climbing stairs to the stage. For the first time, our eyes meet. There’s a lot of them and only one of me.

German and American national anthems, the chaplain’s invocation, more words from some important people, a metal clipped to the chest of my predecessor, and now this: the final salute. Spangdahlem tradition holds that the commander-of-troops calls out during the final salute to the last guy: “Sir, it was an honor to serve with you!” For the first time in two years the guide-on is passed back to the group commander, whose friendly eyes now calmly look into mine. He extends the guide-on toward me, and for a half second I can still say no.

Except I can’t really. Who in their right mind could? I went to medical school—perhaps like you—to serve others and make healthcare better. This was an opportunity like no other to do exactly that.

So I accepted.

The guide-on was neither as heavy nor as awkward as I’d anticipated. Then came that first salute we always hear about. It represents so much. In that moment I knew that I had what it took, which was simply a willingness to step forward, answer the call, look after the team always and be myself.



Day One

Our superintendent and administrative assistant have big smiles, grinning from ear to ear at the new guy. Someone hands me a phone, a radio brick, a stack of important papers and a ring of keys. The Log-Dawgs show up with a Varidesk. Can it get any better? And then it did. The last guy left a hand-written note of encouragement and confidence in the cabinet. Total class and style.

I opened Outlook for the first time on this fancy mail.mil network and my computer promptly gave up the ghost. My first Commander’s Call is in 30 minutes and my talking points are on that computer. Awesome.

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Week One

I've been out of the MTF environment for 2 years, but during this first week much of my forgotten knowledge returns. Apparently my calendar books up by itself. Must be a feature of mail.mil. In a previous life I made the unfortunate decision to create color categories in Outlook, which was the only thing that carried over from the us.af.mil account. Never mind the important stuff. Now my Outlook calendar looks like a bowl of 30-minute-sized Skittles that won't go away.

Week Two

I walked into a stellar team. The last guy left very little unfinished business and there were no messes to clean up. I made friends with the other three squadron commanders. One is new like me, and we've noticed many strangers on base are quickly becoming friends.

Month Two

It feels like I accepted the guide-on and returned that first salute just a week ago. Time flies when you're having fun. Did I just say that? Yes, it really is fun. I'm entrusted with the care of others and our mission. Some days are good. Some days not so good. But every day is worthwhile. For those uncertain whether squadron command is right for you, I'll say with certainty that this is one place in military medicine where you really can make a difference in the lives of others and serve the mission with great impact. Maybe you should give it a shot.

A Few Thoughts on Mentoring

I didn't think I was ready for command. There was so much yet to learn about the professional caring and feeding of medics and I didn't want to fail them. That's where mentorship plays a key role in the development of tomorrow's physician-leaders. Each of us should seek mentors who have traits and skills we'd like to learn. I have a five-member personal board of directors that I call Preston's Fab-Five. These are leaders I turn to for advice in specific situations. No two of the Fab-Five are alike, and only two are physicians. Having trusted mentors is essential because they're willing to provide feedback that's real...and it may not always be what we want to hear. It's objective, and it's wise when I am not.

The MyVector tool has a new "Mentoring Connections" tab that makes mentoring a snap! Once you've identified your own Fab-Five, simply start an asynchronous chat conversation. For civilian mentors unable to provide CAC authentication, email still does the job. Waiting on your first mentoring responses is also the perfect time to focus your sights on the next generation. We need to grow our replacements, right?

Find the shiny pennies out there and learn where they want to go with their careers. Offer to be their mentor or help get them connected with mentors who are right for them. Identify their strengths and ensure our Air Force capitalizes on those strengths by getting them into the right jobs. Grease connections for them! I tell every lieutenant colonel to work with five majors, and I tell every major to work with five captains. Captains should focus their sight-picture on medical students. Once you've got your first five mentees rolling, turn your attention to our highly trained flight surgeon colleagues who are burned out and looking to hang up the flight-suit. Change their minds. Find out what they need and start building bridges for them. Time to re-blue. Let's get after it. 🇺🇸

