FLIGHTLINES

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Words from the Wise

President's Column

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

Greetings! Welcome to 2020! The pace isn't slowing a bit! What an interesting year it is going to be. It has already started off with a bang: a novel coronavirus epidemic with quarantine of evacuees on military installations, impeachment proceedings, election year shenanigans, oh yeah…and, a team from Kansas City actually won something! And, we haven't even begun talking about all of the change happening in the AFMS and/or MHS. Make sure you're buckled in – 2020 is sure to be quite a ride!

It is easy to become distracted in the midst of all of this change. Don't let that happen to you! Why is it that you do what you do? What's your passion? Or, as some of late have asked, "What's your why?" If you can't pretty quickly answer that question, I'd encourage you to spend some time thinking about it. It is hard to be devoted and passionate about something that you can't name or describe. I'd harken us back to the USAFSAM motto "Volanti Subvenimus," which translates to "we support the flyer." Everything we do should be centered around providing world class operational mission support and care to our flyers and their families. If you're seeing changes afoot that don't seem to be aligned with this focus, I'd encourage you to have a heart-to-heart with your leadership and reengage on these issues and decisions. Remember, the goal of the OMRS transition was to make the care of all active duty members look exactly like what traditional flight medicine care of the aviator has always looked like. The goal was never to change flight medicine care to resemble what other active duty care has traditionally looked like. In fact, that would be exactly 180 degrees opposite of the plan and goal of the OMRS transition. Further, I'd argue that it is hard to be passionate about a mission that you never see and/or don't understand. You have to get outside the walls of the MTF to see the mission and to develop the relationships critical to making a difference in providing meaningful mission support. If that isn't happening, it is going to be hard to have the relationships, understanding, or passion necessary to be seen as relevant and mission critical by our operational line counterparts. Don't let the young hygienist who has the flying squadron commander in his or her dental chair be incapable of naming the only airframe flown on the installation. There should be no member of your squadron that could ever happen to! You can't be wholly focused on supporting the mission if you don't even know what it is!

This issue of FlightLines is full of editorials and information that should stimulate lots of discussion and thought about these topics: AEROVAC missions in the Pacific, reading strategies to improve your leadership, the prerequisites to be a flight surgeon, and a summary of recent news in medical journals. You may not agree with each editorial on every single point, but we can't be afraid to ask hard questions and have difficult conversations. After all, that is something we do for things we're passionate about, right? Why are you doing this? What's your passion?

Don't forget about the annual scientific meeting of the Aerospace Medical Association (AsMA) this May 17-22, 2020, in Atlanta! Hope to see you there!

Slash

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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.

From the Editor

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

What a great year! In 2019 we celebrated some amazing milestones in aerospace history. One of my favorites was the 50th anniversary of the Apollo 11 mission. I celebrated with some fellow RAMs at the National Mall, where the National Air and Space Museum put on a great event and presentation about the history and details of that historic launch. I can only imagine the honor it would have been to play a part in those historical moments.

When Neil Armstrong took that first step onto the lunar surface, he announced to the world, "That's one small step for man, one giant leap for mankind." Well … at least that is what the world heard. Interestingly, one of the most famous one-liners in history was not what Armstrong claimed to have said. He intended (and probably did) say, "That's one small step for A man…" However, the "A" was inaudible. This difference in semantics may have been small, but he certainly felt it was important.

We often have different perspectives and see the world through different colored lenses. Sometimes these differences are like semantics: small on the surface, but important. This edition highlights some perspectives and solutions to help you to consider how you see the mission and what role you choose to play in tomorrow's history.

Notice!

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

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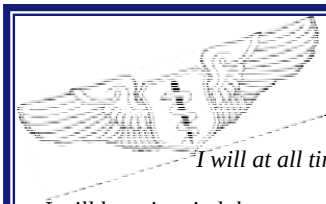
Help SoUSAFFS Grow!

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.

Flight Surgeon Oath



I accept the sacred charge to assist in the healing of the mind as well as of the body.

I will at all times remember my responsibility as a pioneer in the new and important field of aviation medicine.

I will bear in mind that my studies are unending; my efforts ceaseless; that in the understanding and performance of my daily tasks may lie the future usefulness of countless airmen whose training has been difficult and whose value is immeasurable.

My obligation as a physician is to practice the medical art with uprightness and honor; my pledge as a soldier is devoted to Duty, Honor, Country.

I will be ingenious. I will find cures where there are none; I will call upon all the knowledge and skill at my command. I will be resourceful; I will, in the face of the direst emergency, strive to do the impossible.

What I learn by my experiences may influence the world, not only of today, but the air world of tomorrow which belongs to aviation. What I learn and practice may turn the tide of battle.

I may send back to a peacetime world the future leaders of this country.

I will regard disease as the enemy; I will combat fatigue and discouragement as foes; I will keep the faith of the men entrusted in my care; I will keep the faith with the country which has singled me out, and with my God.

I do solemnly swear these things by the heavens in which men fly.

Around the Air Force

You Are Never Alone

James Hougas III, Maj, MN ANG, MC
133 MDG

Deployment in the Medical Corps often occurs as a single person from a base joining strangers on the other side of the world. This can be especially true in primary care taskings. There can be times where you are the only physician for miles. It can be really easy to feel isolated. Resist that feeling because, using DSN or email, you are never truly alone.

My deployment was one for the record books and it gave me plenty of opportunities to feel on my own. During my 189 days deployed, I flew more than 20,000 miles, slept or worked on five different bases in four countries, and practiced medicine in three different time zones. There were plenty of times where I was the only physician. There were plenty of times I felt alone. Help was a simple phone call away and it brought me a community that I needed.

Along the way, I encountered several professional and personal challenges that would have been far more difficult had I approached them by myself. As a family physician, my experience with intubating and sedating patients revolved around the use of midazolam and fentanyl. My drug cabinet had very small amounts of these drugs but instead was full of ketamine. I reached out to friends and found an active duty anesthesiologist who spent 45 minutes talking through the use of ketamine in the trauma patient for intubation and continued sedation. He stayed on the phone with me until I felt confident. Another day, I had a patient with isolated glossitis. I called the on-call Tripler Army Medical Center ENT resident so I could get a specialist opinion on something that I had never seen before and needed a quick consultation. We came up with a treatment and follow-up plan and returned him to duty.

At my Role 1, I had the opportunity to care for some military working dogs. One developed a dermatitis and another lacerated his paw. Sending them via air transport would have left us without their skilled bomb sniffing noses. The veterinarian in Iraq helped me keep these valuable resources in the fight. I became the vet's eyes and hands and kept the dogs doing their job. They also sent a trauma guide along to care for these canines so I could be prepared to treat them should they get severely injured.

The long hours, separation from family, and missing my friends back home were really hard at times. After being forward deployed, I used the DSN to reach back to my clinic to talk to my friends about life and medicine. It allowed for a different type of decompression than my family could provide and brought me back into a circle of peers. It helped me feel like someone who wasn't in a tent and 6,000 miles from home. It also reconnected me to the mission back home that I missed.

Every time someone took my call, he or she was clearly excited to be helping the downrange mission. I had never met any of them, but we were united in the want and desire to care for our deployed. Everyone asked me about what I was doing and took interest in me. They cared.

Final tip: you can use the DSN to call the Travis AFB switchboard and they can dial any U.S. commercial phone number for you.

In Case You Missed It...

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

Know Thyself

We've all been there—60 minutes behind, scrambling to get through the day, and the last patient is requesting an opioid medication. As it turns out, that person is more likely to get an opioid. Specifically, 33% more likely because the appointment is near the end of the day, and 17% more likely because of the clinic delay.[1] It seems to make sense, and you might wonder why we would even look at that in a study. Frankly, the first step to treating a prescribing problem as a provider is to admit that you may have a problem. Recognize it, then work with your providers to effectively huddle and manage their schedules to see what can be done. For more help with opioids, the HHS has released a new guide advocating longer tapers and other strategies for chronic opioid patients.[2] The VA/DoD 2017 guide is also useful.[3]

N95 Not Gonna Work

The N95 mask is held sacred in the halls of medicine, but is it worthy? In the ResPECT trial, 2862 healthcare providers at seven centers were randomly assigned to use an N95 or a simple medical mask. Over four consecutive flu seasons, there was no difference in influenza and influenza-like illnesses. The authors offer a good explanation for medical mask success – anything that prevents "hand-to-face contact" will be effective. There are many limitations to this study, but most of them fall along the distinction of reported N95 efficacy and its real-world effectiveness when used by people.[4]

Adding Adenosine

One of the greatest challenges as a provider is trying to manipulate a stopcock on IV tubing in the midst of pushing adenosine on a critical patient. Fear not! In a study of 53 adults, mixing 6 mg of adenosine into a single syringe with 18 mL of saline was more effective than trying to keep them separate (73.1% vs. 40.7% conversion).[5] This isn't standard practice yet with such a small study population, but it may be worth considering for providers looking to simplify their lives.

Other New Guidelines

The 2007 ATS/IDSA guideline for diagnosis and treatment of adults with community-acquired pneumonia has been updated.[6] Healthcare-associated pneumonia, written out of the hospital-acquired pneumonia guide in 2016, is officially no longer a medical diagnosis. Also, amoxicillin is the preferred outpatient option in patients without comorbidities.

Other Honorable Mentions

The U.S. Preventive Services Task Force has updated recommendations for BRCA-related genetic testing, adding a B grade now for using a screening tool on women with a personal history of breast or ovarian cancer and women with certain ancestry (e.g., Ashkenazi Jewish).[7]

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Wither Aerospace Medicine?

William B. "Flounder" Klein, MD, RAM '94
Flight Surgeon, 78 MDG/SGP2, Robins AFB, GA

When I was a young squadron commander, I wanted to command the dental squadron. The dental squadron commander had a short list of tasks, good people, and one Air Force Instruction (AFI) to deal with. In aerospace medicine, we had good people, many different tasks to accomplish, and more AFIs than I could count. Of course, I am kidding—being a flight surgeon is still the best job in the Air Force, and leading them is amazing. Also, I would never be allowed to drill skulls or do annual dental exams to help out, because I was not qualified to do so, not having been to the requisite schools, obtained the right clinical privileges, etc. In the Air Force Medical Service (AFMS) today, however, we have individuals claiming they are qualified to be flight surgeons who have not had the requisite training (MD/DO) to make them competent to practice aerospace medicine. I appreciate the value these medical extenders have (we had an awesome physician assistant (PA) in the flight medicine clinic who just retired). They do not, however, represent equivalent capability. A family practice physician averages 15,000 clinical experience hours coming out of his or her program, while a nurse practitioner (NP) with no prior nursing experience can finish with 500 clinical shadowing hours and a PA will have about 2000.1 This order of magnitude difference is the difference between someone who can succeed in-garrison with adequate supervision or act independently in a remote location with limited resources. Independent aeromedical dispositions must be made by a provider with enough experience to solve problems with incomplete data and sparse resources. The PA or NP communities do not agree with this assessment, as can be seen in the long-running disagreement that extends into the civilian sector.2 Despite this disagreement, we need to clearly state that being a physician is a necessary prerequisite to being a flight surgeon. Attempting to support aerospace operations with less is reckless.

This issue highlights a disturbing trend in the AFMS: diminishing the role of aerospace medicine in the AFMS. Either through benign neglect, or malicious intent, there is an assault on aerospace medicine in the Air Force. The aforementioned dilution of flight surgeon qualifications is one example of this. Additionally, the Air Force is strangulating the Residency in Aerospace Medicine (RAM). There was a prohibition forbidding General Medical Officer flight surgeons from applying this last Graduate Medical Education cycle. This has since been undone without any clear explanation of the policy or its undoing. The AFMS was reminded by the Aerospace Medical Association, the American Board of Preventive Medicine, and other concerned advocates that they did not have the authority to turn a specialty into a subspecialty, which may have contributed to the policy reversal. Nevertheless, the damage is done; some individuals I know would be starting the RAM if not for this clumsy attempt to limit the program. Harder to gauge is the number of flight docs lost to the RAM because they are being actively dissuaded from applying by their mentors/leaders. I recently ran across a flight surgeon I was stationed with a few years back who has since been a successful Chief of Aerospace Medicine and aerospace medicine squadron commander. He is being told by his leadership that the RAM would be a waste of time for him as a young lieutenant colonel. Unfortunately, I have run across other flight docs who are being told to avoid the RAM, and evidently this is having an effect, as there are no direct entries into the phase II year of the residency this year. Zero. That is scandalous. That the AFMS leadership is not concerned illustrates the shift in the center of gravity of the AFMS away from aerospace medicine.

The Air Force has created three "residency-like" programs to compete with the RAM for advanced operational medicine training. It is hard to imagine a rationale for this, considering the RAM has so few applicants. Of course, if the intent is to kill off the RAM, then creating other options to distract potential applicants makes sense. This demonstrates another trend in the AFMS of delinking aerospace medicine and operational medical support. It used to be that these terms were synonymous, but not anymore. Aerospace medicine is about to be wiped off every squadron patch in the AFMS with the impending AFMS reorganization. The name change is unnecessary and impractical, but is a good indicator of how little our senior leadership values Team Aerospace. If you need more evidence of this, take a look at the Strategic Initiatives Summary that came out from Air Force Surgeon General in May 2019. It is all about casualty care and makes no mention of human performance improvement, prevention, public health, occupational assessment, physical standards, or any other core activity of aerospace medicine. As one of my colleagues put it: "A century of combat experience, aeromedical support systems, and mission success, down the tubes." Part of this deemphasis is our own fault by not clearly articulating what we do and why. As a community we grew complacent, because in the past all the AFMS senior leaders were flight surgeons and most were RAMs…so they already "got it." Those days are gone, and we can no longer assume our leadership has a clue as to what real operational medical support is. We have to clearly demonstrate to the AFMS what we have always demonstrated to the line of the Air Force: if you are going to fly, fight, and win, you better have someone in your corner who can help you maximize your performance. Whether that is manifested by dispensing go-pills, doing an inflight occupational assessment, or taking care of someone's family (which is under threat, by the way), a proper flight surgeon (MD/DO) is the one best equipped to handle it.

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A Report of the C-12J, the Air Force's Newest AE Platform in the Pacific

Thomas Powell, Capt, USAF, MC, FS
Operational Emergency Medicine Resident

Since the departure of the C-9A from Yokota in 2003, a dedicated U.S. Air Force (USAF) aeromedical evacuation (AE) capability in the Northwest Pacific has been conspicuously absent. AE operations have since been delegated to two primary platforms stationed in the Northwest Pacific: the KC-135 at Kadena AB and the C-130H at Yokota AB. Both these airframes are considered by the USAF to be standard AE platforms for patient movement, and these airframes comprise the majority of the patient movement missions. All USAF flight nurses and technicians serving in an AE capacity are qualified on all three of these airframes, allowing simple mission facilitation. In this region, patients of all three categories, routine, priority, and urgent, are flown with regularity on these platforms, but only in small numbers per mission. Current operations tempos heavily task these precious airlift and tanker assets. The current AE regional mission tempo involves moving small numbers of patients over relatively short distances of 500-600 nautical miles, usually in a weekly rotation. Tasking these assets is costly, both from a monetary and logistics perspective. Further, these airframes require a long alert and preflight time and lack the inherent flexibility of smaller airplanes for regional operations.

In Europe, many military-operated local AE missions are performed in the C-21A, the region's lightest operational support airlift (OSA) asset. In the Northwest Pacific, only one fixed wing USAF OSA asset remains, the C-12J. Occupying the middle ground in terms of size and cargo capacity between the two aforementioned aircraft, the C-12J is a local workhorse, flying 2500 hours per year between three aircraft supporting VIP, priority cargo, and other niche missions throughout the region where timely support is desired. Although it carries the C-12 designation, the aircraft is based on the Beechcraft 1900C regional airliner and is equipped with a more spacious cabin and greater cargo capacity than the standard military C-12. Operated around the world, this aircraft is a proven AE platform in the civilian community. An FAA-certified variant of the cabin can be equipped with as many as five aeromedical beds. Upon learning of the nature of the AE taskings in the region, the 459th Airlift Squadron, the Air Force unit operating the C-12J for PACAF, proposed to outfit its aircraft to support regional AE missions. The C-12J ideally fits the leg distances between bases inside the Japan/Korean region. Using standard operating costs, the unit determined that if a C-12J replaced the KC-135R for half of the routine AE movements, cost savings would be $2 million per annum. This figure does not include the value added of freeing the traditional assets up for other missions, which allows the USAF to utilize these assets in the most effective manner possible, such as humanitarian aid and tanker support to other aircraft.

The C-12J is actually a Beechcraft 1900C, a proven air ambulance platform.

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The C-12J in the Pacific is operated similarly to its civilian analog with a passenger capacity of up to 18, a reduced seating cargo-heavy configuration, or a mixture of both, the layout of choice on most OSA missions. Such a configuration would allow the C-12J to perform dual missions, with patient transport occurring alongside defense courier service, important cargo airlift, or even a small party of officials for VIP transport. This flexibility would allow the USAF to task the C-12J to the maximum extent possible to achieve an optimized cost gained per flight hour.

To evaluate the efficiency of the C-12J compared to other airframes, numbers for hypothetical, yet realistic missions to run using flight planning software and a comparison of required ground and alert times for the KC-125R, C-130H, and C-12J were developed. A typical weekly AE mission to transport routine patients in the region starts on Okinawa, moves to Korea to pick up patients, then over to one of the bases in mainland Japan, and finally back to Okinawa to prepare the patients for movement to either Guam or Hawaii. Such a movement requires two flights from either a KC-135R or C-130H, with a similar number of flight hours at a much higher cost. In addition to the fiscal advantages, the C-12J requires an alert time (time to notify for flight before takeoff time) of only 3 hours, which could realistically be reduced to only 2. This compares favorably to the 4.5-hour times required by both the C-130H and KC-135R.

To comply with USAF AE regulations, a "get down" litter must be installed on all aircraft transporting patients of the "routine" category the C-12J is proposed to support. With funding of an experimental proposal dubious at best in the "sequestration" environment that existed at the time, both C-12J crews and 18th AE personnel had to get creative in evaluating the aircraft for suitability for AE missions and developing guidance on how to properly integrate the aircraft into the AE world. Per USAF regulations, any time patients of any condition are transported on an aircraft, a litter that serves as a "get-down" bed for patients undergoing a serious in-flight medical emergency must be installed; this serves as a platform to resuscitate and attempt to stabilize acutely critical patients. Fortunately, unused aircraft modification funding was found that allowed the squadron to purchase a Spectrum Aerobed model 2800, the same bed approved to fly on the Beechcraft 1900C air ambulance. The 2800 is a self-contained litter that has suction, oxygen, AC power, and its own detachable all-aluminum litter that allows for easy patient loading and unloading. Furthermore, the three C-12Js at the 459th were further modified to provide additional AC power outlets for additional medical equipment if required.

Flight nurses and technicians from the 18th AES at Kadena AB learn to use the Spectrum Aerobed onboard the C-12J.

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AE transport on the C-12J is limited to the movement of routine and non-critical patients only. The aircraft's pressurization systems are not as extensive as other USAF aeromedical assets. This presents an issue with the transport of patients in critical condition. With a maximum pressurization of 10,000 feet, the aircraft presents certain physiological issues that make transportation of a critical patient unacceptable. Further, the standard aircraft speed of 260 KIAS is likewise undesirable for swiftly moving these patients. Although its operation as a critical "air ambulance" is unrealistic in this region, the ability to transport non-critical patients cheaply, reliably, and expediently offers a previously untapped mission that cannot be ignored. With the correct application, the C-12J will prove an invaluable asset in the transport of patients to the various medical facilities in the region, increasing the efficacy and timeliness of patient care once adequately integrated into the AE mission. Patient transport, crew member training, and rapid response all represent qualities that will add incredible value to military AE operations in the region.

Now 3 years operational, the C-12J is a regular contributor to the weekly PACAF AE routine patient movement mission, participating along the chain in nearly 80% of AE missions in the region. It also serves as an inexpensive airborne training platform for members of the 18th AE to receive regular ground and in-flight training. This mission has also allowed the C-12J to become a regular participant in regional humanitarian efforts and exercises. To date, medical personnel from the Japanese, Australian, New Zealand, and Philippine armed forces have received training or been observers of training on C-12J aeromedical mission training flights. These multilateral events help to strengthen bonds between nations and standardize procedures throughout the region. Highlighting this project is an important example to the aeromedical community of what can happen with a little ingenuity and teamwork. Identifying and developing capabilities in flexible airlift assets will continue to enable the USAF's AE mission to remain potent and flexible into the future.

JASDF physicians from the AME squadron learn about the Spectrum Aerobed onboard the C-12J.

What's on Your Nightstand, Leader?

Eric "De-Mo" Chumbley, Col, USAF, MC, SFS
Commander, 78 OMRS, Robins AFB, GA

Guys, I love a good book. Audiobooks have kept me sane on many a run and cross-country drive. The instant gratification of downloading an interesting selection found through Goodreads can make a weekend for me. And of course, there's nothing like the heft of a great biography when the weather turns cold and the daylight is short. The opportunity to add another leader's successes and failures to my own knowledge base is irresistible. So, for those who might be on the lookout, here's a short list to get you started on the leadership reading road.

Start with Why: How Great Leaders Inspire Everyone to Take Action. No kidding, this book transformed my thinking. You know what you do, and you know how you do it. Have you really, deeply considered why you do it? There's something you're built for. Doing something else is a waste of your time. Simon Sinek has a great way of getting to the heart of the matter, which is largely your heart. If you're struggling with motivation, either yours or your team's, this book is for you.

The One Thing: The Surprisingly Simple Truth Behind Extraordinary Results. Having difficulty solving a problem? Years ago, I began to realize when I faced an apparent gordian knot, it was frequently because I was asking the wrong question. So, I started looking for opportunities to reframe my questions. Later, I learned to be more careful from the start. Einstein reportedly once said if he had 1 hour to solve a problem, he'd spend the first 55 minutes defining the problem, and the last 5 minutes on solutions. Gary Keller's The One Thing tackles the same topic. He teaches you to ask where you should focus your time and effort, such that when that job is done, everything else will be easier or irrelevant. Isn't that what you're already doing with all those CPIs?

Dare to Lead: Brave Work. Tough Conversations. Whole Hearts. I am not very blue. I'm a pretty solid gold with a big shot of green. I would not be surprised to learn that you are, too. In the past, I would typically think about how a teammate feels only when pressed. See my comments on The One Thing. Brené Brown seems to find that unacceptable. Come to think of it, if I ever meet her and really open up, I expect a smackdown. Watch her on YouTube or read her book, and you'll see why I write that. Dr. Brown does not play around. She wants you to unleash the power of relationships, to make your team feel safe to excel. If, like me, you need a dose of empathy in your leadership, read her work. I don't have this figured out, but at least it's on my radar now.

Leaders: Myth and Reality. For those who wonder if they're cut out for leadership, let me point you to retired Army General Stanley McChrystal, who will challenge you to reconsider what a leader looks like. He begins with a personal journey from being a youngster who idolized Robert E. Lee to being a senior leader who saw significant flaws in a man who would take up arms against the nation whose constitution he had sworn to protect. In the name of defending slavery. Yeah, he's pretty blunt about it: myth, busted. But keep going, because he continues with six pairs of contrasting leaders who got the job done despite varying approaches. He'll try to convince you that leadership is contextual and there is no one right way to lead. You might finish the book wondering if a leadership style that succeeded in one time and place could well fail in another.

Growing Physician Leaders: Empowering Doctors to Improve Our Healthcare. I consider this essential reading since my friends JUNC Speakman and HOPS Hatcher gifted it to me prior to RAM graduation. And despite the title, it's not just for physicians. Retired Army Lieutenant General Mark Hertling commanded armor units for decades. Turns out, he knows stuff. This is a real nuts and bolts book aimed at causing you to genuinely consider who you are and who you want to be as a leader, with some very helpful suggestions. What do you value? How well do you lead yourself? Your boss? What's the big picture? It was my first exposure to the staff ride. Read this book.

Conduct Under Fire: Four American Doctors and Their Fight for Life as Prisoners of the Japanese. 1941-1945. You think you have problems with DHA, medical group transformation, promotion, assignments, flying time, the Colonels Group, or anything else? Read that title again. John Gusman is here to teach you about his dad and three other Navy docs whom the Japanese captured on Corregidor in May 1942. This book changed my perspective. My worst day on the job would have been a blessing to these medics. Would I have held up honorably under the circumstances?

As I write this, I'm staring at a bookcase that's probably 80% history and biography, 10% pure leadership, and 10% fiction. That doesn't count the iPad. And now I'm really curious: What's on your nightstand? 🙏