



Alliance of Air National Guard Flight Surgeons

Strategic Plan

As approved at the annual meeting of the Alliance, 7 Nov 99

Executive Summary: Recommendations

1. Flight Surgeons Flying: The Alliance firmly supports the continuation of the requirement that flight surgeons must fly “regularly and frequently” with their squadrons. For those situations where the weapons system precludes the FS having regular participation in that squadron’s mission, the FS should fly regularly in other aircraft, to familiarize her/himself with the unique aspects of military flight operations.

2. New missions for the ANG:

- **WMD’s:** Since the defense of our homeland is most assuredly a traditional National Guard mission, the Alliance emphasizes the ability of ANG units to contribute to homeland defense, expanding coordination with civilian state units (“Military Support of Civilian Authorities”). Medical assets in particular are the greatest asset the State has within the Air National Guard, whether the threat is a natural disaster or a terrorist attack.
- **EAF:** The incorporation of ANG medical assets into the Expeditionary Air Force concept is still being worked out at higher levels. The Alliance, on a close vote, prefers to support separating medical assets from their own wings, except the SME’s whose flight surgeons would expect to deploy with their flying squadron. For most reserve physicians, the 2-week cap must still apply (except in the case of a PSRC).
- **Space Operations:** The Alliance takes the position that the space war fighters are also best cared for by flight surgeons.
- **EMED Team:** The Alliance supports the placement of ANGMS personnel on the EMED development team in order to ensure that the valuable medical assets within the ANG are properly utilized.

3. Outsourcing: The Alliance states firmly that the aerospace medical program must never be outsourced. However, it accepts the possibility that outsourcing may be necessary or even preferable for certain professional functions, to include:

- Dental
- Non-aviation medical
- Non-aviation optometric

4. Recruiting and Retention of physicians:

- Flying emphasis: Recognizing that opportunities for flight surgeons to fly in fighters are decreasing, and may well disappear altogether in time, the Alliance recommends that recruiters should emphasize the positives of tanker/transport flight, and the other opportunities such as ICE³ and OCONUS humanitarian missions.
- PME: The Alliance (not unanimously) is on record as stating that PME is a value-added requirement that should be retained, even emphasized. Programs such as Jumpstart that make PME more readily available to busy professionals should be expanded. Distance learning and other innovative methods should be developed.
- Flexibility: The Alliance suggest exploration of alternative ways that professionals can accomplish training and fulfill their military obligations, including programs similar to the CHEERS program for CME that the AFRC has. A 30-day rotation every other year should suffice for two good years (this would require a statutory change).
- Bonuses: The Alliance believes that bonuses are likely to significantly influence today's physicians, and that therefore the expense is justified.
- Promotions: The Alliance is concerned that we are losing physicians in significant numbers because of various limitations imposed on promotions. If possible, there ought to be a way that an O-6 commander can step back to a lesser billet later in her/his career, but still retain the rank and retire at O-6. Recapture of lost O-6 billets for State Air Surgeons should be pursued.
- Top Programs: The Alliance strongly supports the prompt restoration of the Top Knife Program within the Guard, as well as the other Top programs. This is very important for recruiting and retention.

5. CyberGuard: The Alliance encourages the ANGRC to speed up the process of removing the effect of firewalls, and facilitating access for flight surgeons to do ANG business from their office/home PC's. It should encourage the ANGRC routinely to disseminate vital information--such as the Heads-Up, SG Log Letters, and TDY opportunities for flight surgeons--directly via e-mail to flight surgeons at their offices/homes, perhaps utilizing the DMS (Defense Message System).

6. Inspections: The Alliance recommends that the HSI be incorporated into the wing's ORI, or perhaps better, the UCI, and not a separate inspection.

7. Combining the Alliance with the Association of AFRC Flight Surgeons: Recognizing that we are a distinctive culture that includes our unique state mission, we will not readily be absorbed into a homogeneous ARC. The Alliance should explore ways to work more closely with the Association of USAF Reserve Flight Surgeons, yet retaining our separate organizations. The Alliance further recommends the creation of a system that allows essentially transparent transfers within the ARC (ANG and AFRC), with minimal paperwork, no hassles, delays, etc.

8. Human Weapon System Council: The Alliance recommends that a council, modeled after the Weapons System Councils that exist within the ANG, be created to discuss current concerns in a timely manner, and to coordinate responses. This Council might function on the web as this committee has done. Suggested members are listed on page 16 of the notes. This committee also recommends that a flight surgeon or two be added to the existing Weapons Systems Councils if possible.

Note that there are several other areas of current interest that the Alliance did not get a chance to explore this year, and therefore did not take a position. For example:

- Proposal from some quarters that the medical squadron be placed organizationally under the Ops Support Group, a terrible idea from several angles
- Anthrax
- Tri-Care
- Our role in physical health and fitness, a force protection / force multiplier issue
- Our role in family support of deployed members

Strategic Planning Committee Notes

Commission:

- Assigned at Board of Governors meeting, 18 May 99
- To analyze current trends and situations, particularly with respect to recruiting, retention, and utilization of flight surgeons;
- To examine why we exist as Flight Surgeons and as an Alliance
- To evaluate the role of the Alliance in advising the appropriate authorities
- To project how the Alliance should shape itself for the future of aerospace medicine in the ANG.

Reporting Authority: The Alliance Board of Governors, who will pass the report on to:

- The Alliance membership
- ANGR/SG
- ANG Assistants

Suspense Date: AMSUS-99 (Nov 99)

Members: (alphabetically)

- Col Bob Andrews, MEANG (SAS ME, AMC)
- Col Randy Falk, TXANG (past ANGR/SGP, SAS TX)
- Col Gerry Harmon, SCANG (*Newsletter* editor, SAS SC, ACC)
- Col Bob Janco, TNANG (past president, SAS TN, AMC)
- Lt Col Clee Lloyd, ORANG (treasurer, SAS OR, ACC)
- Col Kirk Martin, FLANG (past ANGR/SGP, ACC)
- Lt Col Carol Ramsey, ANGR/SGP
- Col Phil Steeves, MAANG (current president, ACC)
- Col Richard Terry, TNANG (immediate past president, SAS TN, AMC)

Plan of Action:

- Phase I, listing the issues, completed Jun 99
- Phase II, gathering consensus on issues and recommendations, completed 30 Sep
- Phase III, final draft approved by entire committee, completed 30 Oct 99
- All committee interaction accomplished on the internet, no face-to-face meetings held

Issue: Should flight surgeons fly?

Factors to consider:

- Why must flight surgeons fly (must answer this question precisely and with authority)
- Unique value of the squadron flight surgeon to the mission
- Loss of two-seat fighters
- Potential eventual loss of all manned fighters
- Increased use of Tanker/transport/bomber aircraft in the ARC
- Use of SME's
- Note results of survey in Spring [Newsletter](#), as compiled and reported by Kirk Martin

Proposal:

The committee recommends that the Alliance take a strong stand in support of the continuation of the requirement that flight surgeons must fly regularly and frequently with their squadrons. For those situations where the weapons system precludes the FS having regular participation in that squadron's mission, the FS should fly regularly in other aircraft, to familiarize her/himself with the unique aspects of military flight operations.

Discussion:

The squadron flight surgeon is uniquely positioned to make aeromedical decisions. These decisions include factoring in knowledge of (1) the individual pilot, (2) the limitations of the aircraft, (3) the particular demands of the mission, and (4) the physiologic aerospace environment. All this information must be integrated with the medical expertise that applies to the situation. We believe that only a physician with additional aeromedical training is qualified to make these judgments.

Clearly, the surest way to gain the necessary knowledge of the pilot, aircraft, and mission is to have the flight surgeon flying regularly and frequently with his/her squadron. The ultimate example of this concept is the SME, which should be expanded if possible to all flying units.

Note that this applies equally to fighters, bombers, tankers, and transport aircraft. The various missions will present differing challenges (e.g., G-LOC in fighters, circadian rhythm disorders in long range aircraft), but the value of the qualified, current flight surgeon is unique. As long as the aerospace vehicles have a human on board, we believe flight surgeons should be part of the process, from design through manufacture to employment.

Issue: New missions for ANG

Factors to consider:

- Space operations (United States Air and Space (or Aerospace) Force)
- Bombers
- Homeland defense (military support of civilian authorities)
- WMD's
- Shift from a Responding Force to a Shaping Force
- Increased Joint-ness in operations
- Total Force concept for USAF/ARC
 - could we have a transparent transfer between AFRC and ANG where appropriate and necessary
 - ensure a level playing field between the two ARC components
- Active Duty has much of the hard assets (e.g., ATC's, ATH's); can these be moved to the Guard where they could also be accessed for state-level emergencies
- Increased OpsTempo/Deployments
- Expeditionary Air Force
- Multi-polar (multi-national) military engagements
 - nation-building
 - peace-enforcement
- What is our mission in Y2K and beyond:
 - Flying mission
 - State mission
 - EAF mission
 - WMD's
 - Space
- We should mirror the line in looking at...
 - Force Protection (i.e., physicals, immunizations, training, records maintenance, deployment after the base population is supported and deployed)
 - vs. a Medical Strike Team (e.g., CAREFORCE), response to disasters, WMD or otherwise
 - fit somehow into the EMED system
 - we currently have no seat on the EMED team

Proposals:

1. WMD's: The committee recommends that the Alliance emphasize the ability of ANG units to contribute to homeland defense, expanding coordination with civilian state units ("Military Support of Civilian Authorities"). The defense of our homeland is most assuredly a traditional National Guard mission. Medical assets in particular are the greatest asset the State has within the Air National Guard, whether the threat is a natural disaster or a terrorist attack.

2. EAF: The incorporation of ANG medical assets into the Expeditionary Air Force concept is still being worked out. The committee, on a close vote, prefers that the Alliance support

separating medical assets from their own wings, except the SME's whose flight surgeons would expect to deploy with their flying squadron. For most reserve physicians, the 2-week cap must still apply (except in the case of a PSRC). A variation allowing 30 days every other year should be considered. Rotation time must be reasonable, including transportation time, and preferably beginning and ending on weekends rather than mid-week.

3. Space Operations: The committee recommends that the Alliance take the position that the missileers and other space war fighters are also best cared for by flight surgeons. We must be able to justify why space ops need flight surgeons as much as aviation ops.

4. EMED Team: The committee recommends that the Alliance support the placement of ANGMS personnel on the EMED development team in order to ensure that the valuable medical assets within the ANG are properly utilized.

Discussion:

1. WMD's: The National Guard, having evolved from the original state militias, has a traditional mission of protecting our citizens from harm, and assisting when harm has struck (natural disasters, and potential terrorist activities). As we are training for war-time taskings that include CBW attacks, aeromedical evacuation, air transport, etc., we are developing skills that ought to be available to domestic agencies which have essentially similar missions at home.

2. EAF: The predictability of deployments that the EAF should bring is an important retention consideration for busy Guard physicians. Medical assets may well be put on a completely different schedule of potential deployability than the wings are. This ties into the SME question; SME docs will presumably go with their flying squadron. However, higher authority may try to lump all medical assets together, without respect to individual units. At a time when the active force is shrinking, and new war plans are calling for expanded medical support, we have a golden opportunity to stand up to the need, and ensure a valid mission for our medical service members now and in the future. The ANG physician represents a low-cost / high-capability medical asset both at home and abroad.

3. Space Ops: Space war fighters (including missileers and those working with satellites and Information) have unique psychological stresses that are best handled by physicians with the special military/medical training of flight surgeons.

4. Any relook at mission requirements and taskings must include the ANGMS, especially as military support of civilian authorities is expanding with an increased expectation of using ANG medical assets for local responses to terrorist and natural disasters.

Issue: Outsourcing

Factors to consider:

- Outsourcing (esp professional services; which areas can be outsourced, which ones must not be outsourced)
- Flight medicine not amenable to outsourcing
- Flight optometry also requires special aviation training, cannot be outsourced (except to optometrists with aviation background)
- MITS may make outsourcing of immunizations impractical
- Other professional services can be outsourced
 - Non-flying medical
 - Non-flying optometric
 - Dental
 - Use of physician-extenders (PA's, NP's)
- Must anticipate some controversy from affected professionals (e.g., dentists) about a recommendation to outsource

Proposals:

1. The committee recommends that the Alliance state firmly that the aerospace medical program must never be outsourced.
2. The committee recommends that the Alliance accept the possibility that outsourcing may be necessary or even preferable for certain professional functions, to include:
 - Dental
 - Non-aviation medical and optometric

Discussion:

1. The unique functions of a flight surgeon will always require that s/he be an integral part of the unit, to include flying. Therefore, civilian contractors can never properly fill the role of flight surgeons.
2. If it can be shown to be cost-effective, civilian contractors can handle all the aspects of dental exams and non-flying medical/optometric. In some cases, even if it is more costly to use independent contractors, it may be necessary to do so owing to the shortage of military professionals. Retired military physicians/surgeons may also be useful as civilian contractors in certain situations, and should be authorizable where needed.

Issue: Recruiting and Retention of physicians

Factors to consider:

- Financial incentives
 - medical training loans
 - tuition benefits at state colleges
 - CME courses
 - Are they getting:
 - enough bang for the buck?
 - enough bucks?
- Emphasize other incentives
 - Participate in humanitarian missions
 - Travel
 - ICE-3
 - Frequent pop-up deployments for those who elect to avail themselves of these opportunities (not required)
 - de-emphasize fighters in advertising, recruiting posters, etc (increasingly important)
 - Becoming false advertising, detrimental in long run
- Improve private and military flying opportunities to physicians
 - Allow flying requirements to be met in more imaginative ways
 - Flying clubs
 - Civil Air Patrol
 - All DOD aircraft including USCG must remain allowable to meet flying requirements
 - Simulators
 - We need to be VERY flexible
- Competition with other Reserve opportunities
 - ANG officers often lost to AFRC, USN; examine what they offer that we do not
 - Lack of promotable slots in ANG, state HQ's capturing Medical O-6 billets
 - Why are we so far behind AFRC in:
 - Bonuses/incentives
 - Maybe a bonus for the time "in the box" under the new EAF concept
 - CHEERS program of AFRC
 - additional mandays and \$ for CME
 - But \$\$ often gets co-opted by wing commanders
 - Offer credit for medical meetings not necessarily related to military role?
 - Better coordination among the Active Duty forces to advise ARC of potential recruits (Palace Chase, or even just those getting out when AD has good idea where they are relocating)
- Expanded CME possibilities
 - Develop an ANG CHEERS-type program for CME
 - authorize medical professionals to get CME in their own specialty
 - trainee on orders, wears uniform
 - opportunity to act as ambassador, recruit other professionals

- Provide schedule flexibility to practitioners to accomplish their UTA's/AT's
 - traditional UTA model may have to be modified for docs--very important
 - A statutory change could be effected to allow a 30-day rotation every two years to substitute for 15-day rotations every year
- More accommodation to those in training (residents)--very important
- Promotions
 - the currently required higher grades for older professionals that want to enter the military for the first time may block their accession
 - inability of people with many years of service to down-grade to a lower rank, allowing them to continue to make a contribution at a less intense level than previously
 - Still important to allow young folks to move up; be very wary about encouraging older folks to hang around indefinitely, especially as they are liable to lose touch with the troops in the trenches
- PME
 - Do we support it as a requirement for promotion?
 - Can PME be tailored to physicians? Should it?
 - Can PME be tailored to Guardsmen (reflecting civilian training in leadership and management)? Should it?
 - Create a book/journal club with required readings of reasonable length, distance learning, sessions at AsMA, AMSUS, specifically on PME topics
 - Generate a proficiency and knowledge screening test that would point out areas for improvement, as well as other areas already mastered, perhaps from civilian training, allowing students to "test out" of some areas
- TriCare
- TOP Programs
 - Very useful for R&R
 - Top Hat, new program for TTB, is a good opportunity for all flight surgeons, especially if it can include a multi-day trip to OCONUS
 - Other Top programs just as important for other professionals (Top Eye, Top Drill)
- Do we (should we) wait until the problem is so acute that there are no doctors left to address the issue; will we get more action if it gets to crisis mode
- Can we develop/expand a program for ANG physicians to provide CME education for Active Duty personnel deployed OCONUS
 - Additional opportunities for ANG physicians to travel, R&R incentive
 - Note wealth of academic expertise as documented by AANGFS database
 - Offsetting consideration: OCONUS docs prefer to have an excuse to return to CONUS now and then to see family and friends, and CME is that excuse

Proposals:

1. Flying emphasis: Recognizing that opportunities for flight surgeons to fly in fighters are decreasing, and may well disappear altogether in time, the committee recommends that the Alliance should advise recruiters to emphasize the positives of tanker/transport flight, and the other opportunities such as ICE³ and OCONUS humanitarian missions.

2. PME: The committee recommends nearly unanimously that the Alliance go on record as stating that PME is a value-added requirement that should be retained, even emphasized. Programs such as Jumpstart that make PME more readily available to busy professionals should be expanded. Distance learning should be developed.
3. Flexibility: The committee recommends that the Alliance suggest alternative ways that professionals can accomplish training and fulfill their military obligations, including programs similar to the CHEERS program for CME that the AFRC has.
4. Bonuses: The committee essentially split on the issue of whether bonuses will significantly influence today's physicians, whether the expense is therefore justified. Perhaps there could be a bonus for the time "in the box" for EAF deployability.
5. Promotions: The committee recommends that the Alliance should state that we are losing physicians in significant numbers because of various limitations imposed on promotions. If possible, there ought to be a way that an O-6 commander can step back to a lesser billet later in her/his career, but still retain the rank and retire at O-6.
6. Top Programs: The committee recommends that the Alliance strongly support the prompt restoration of the Top Knife Program within the Guard. The other Top programs are also very important to recruiting and retention of professionals. The latest program proposal is Top Hat for TTB (tankers, transport and bombers), a program that will attract all flight surgeons especially if it can include a multi-day trip to OCONUS.

Discussion:

1. Flying emphasis: The loss of F-16 backseats seems to be all but permanent. Several F-15B's have also been lost to units, sent to Klamath Falls. The F-22 program doesn't even have a B-model, and even the A-model may not be produced. On the other hand, there are very attractive opportunities to fly to neat places in the ANG. The recruiters should stop printing pictures of flight docs in front of F-16s and substitute tanker-transport ops, OCONUS humanitarian missions, etc.
2. PME: This is a hot button issue for the Alliance. See the current and recent *Newsletters* for discussion. For the Alliance to take a position on this issue will disturb some folks. Perhaps it should lead into a discussion of having a non-commander track for some flight surgeons, which would allow them to complete a squadron flight surgeon career complete with high rank, never having to get into admin/command. If the committee chooses to support the requirement of PME, it will likely add that it ought to be made more physician-friendly (expand Jumpstart, get it on the Web or CD-ROM, etc). If PME is to be a requirement for promotion, presumably Air War College will be the prerequisite for promotion to O-6, and for assuming command of a medical squadron.
3. Flexibility: In addition to the discussion of CME programs, the committee may like to make recommendations about schedule flexibility, allowing innovative ways to accomplish the Guard requirements such as combining drill periods into several consecutive days rather than one weekend a month. Of course, with RUTA's and TDY's, some flexibility already exists. TDY's that must be a minimum of 30 days, however, are prohibitive to most practicing docs. Since most physicians can hit the ground running (i.e., jump right in and practice medicine), 7-day

TDY's ought to be feasible, similar to pilots who fly airliners as civilians and tankers in the Guard.

4. Bonuses: Traditionally, physicians seem to lose more money by doing Guard duty than they could have earned in that time as a physician. This may well be changing, considering the changing face of American medicine, with HMO's, physicians on straight salary, etc. It is a matter of debate whether the upcoming crop of physicians would respond to significant cash bonuses. Compare this to the pilot bonuses, which have not been a startling success. Issues such as OpsTempo, family stressors, airline hiring have been more significant.

5. Promotions: The limitations on promotion come from several sources, mostly state headquarters (but see also #2). It seems that the AFRC has attractive positions with higher rank that periodically attract physicians at the expense of the ANG. If the AFRC can do it, the ANG ought to be able to as well. This is a tricky issue, as promotions depend on the state bureaucracy, congressional legislation, UMDs, and ROPMA.

Should we define specific career tracks, similar to tenure/non-tenure in academic medicine. The Command track would require CME, command experience, admin and leadership skills and training, PME, etc, with the expectation of promotion to O-6 and, for a few, higher. By contrast, the Flying track allows one to be the squadron flight surgeon, to participate in operations and deployments, enjoying the priceless rewards of aerospace medicine as a career in the Guard, presumably with a ceiling on rank at O-5. One would have to choose which track s/he is on prior to pinning on O-5. This would eliminate the belief that all ANG docs will make O-6 in 20 or fewer years just by being a good doc. OR do we already have this two-track system effectively in place? Especially with corps-neutral MDS commanders.

6. Top Programs: Top Knife has been on hold for about a year. At first, this was because of the transition from F-16 to F-15. The unit has completed the conversion, and they're doing a lot of flying now with empty back seats. There is supposedly a security issue (secret stuff in the back seat). Whatever the excuse, it seems to require some high level influence to get Top Knife back in business. The Alliance's positive statement on the usefulness of the program and its important R&R value may help to get some action.

Issue: CyberGuard

Factors to consider:

- Removal of firewalls at ANGRC website that prevent flight surgeons accomplishing much needed items from home PC's
 - Concern about security issues
 - Concern about viruses
- Lack of a common-use database for all MDS's that integrate and simplify the myriad programs that have to be filed (MRDDS, CCQAS, CPR stats, etc)
- WIBITS

- Microsoft Office programs are in widespread use
- One-off programs written specifically for mil use often very disappointing
- Information/technology warfare
 - our society is highly dependent on information, computers, and technology. Terrorists could wage war by disabling critical systems.
 - Even disinformation/misinformation on the web could impact our military readiness, e.g., the Anthrax debate
- Improve CyberGuard
 - e-mail direct to ANG flight surgeons (“VFR-direct”)
 - Busy flight surgeons, most of whom are now on the web, need to have one common site where they can go to get the latest relevant info
 - The [AANGFS website](#) is an ideal candidate for this
 - Wherever it is, there must be no firewalls
 - Info should be filtered by someone (perhaps the ANGRC/SGPA) to declutter the messages, so that only info relevant to flight medicine is posted
 - The ANGRC should get updated e-mail addresses of all its flight surgeons, specifically those using home or hospital addresses (as opposed to mil addresses), so that they can check their mail daily as needed.
 - Use these addresses for important messages about flight medicine, opportunities for TDY’s, etc

Proposals:

1. The committee recommends that the Alliance encourage the ANGRC to speed up the process of removing firewalls, and facilitating access for flight surgeons to do ANG business from their office/home PC’s.

2. The committee recommends that the Alliance encourage the ANGRC routinely to disseminate vital information--such as the Heads-Up, SG Log Letters, and TDY opportunities--directly via e-mail to flight surgeons at their offices/homes. As the DMS (Defense Message System) comes on line, this may well be the best vehicle, as long as there are no firewalls, and the civilian e-mail addresses can be employed if desired by the addressees.

Discussion:

(For both 1 and 2). Most physicians are now computer-literate, comfortable with going on the web for medical information, etc. And most do much of their Guard work at home. Sending vital info from the ANGRC to the medical squadrons and expecting it will then be distributed to the doctors in a timely manner has not been working well. There should be routine, direct communication between the ANGRC and the flight surgeons. This could include, in addition to what is mentioned above, narrative summaries, waiver application information, etc.

Issue: Inspections

Factors to consider:

- Inefficient utilization of physicians' time to be doing volumes of needless paperwork
- But there is valuable experience bringing a unit to an excellent level of performance and readiness
- Tool for promotion
- There is certainly wasted time preparing for multiple inspections
- Expectations that paperwork will be processed on non-reimbursed time
- We should concentrate on only Value-added items, whether inspectable or not
- Must eliminate all non-Value-added items, both on duties and inspections
- Recently, the IG Team seems to be more the good guys, here to help, compared to the old days when they came only to criticize
- Much improved dissemination of helpful info lately by email from AFIA

Proposal:

The committee recommends that the Alliance recommend that the HSI be incorporated into the wing's ORI, not a separate inspection.

Discussion:

The separation of the HSI from the ORI leads not only to the feeling that we are continually in an inspection mode, just moving from one inspection to another, but also to the idea that the medical folks are somehow a breed apart from the rest of the (i.e., the real) military forces.

Issue: Combining the Alliance with the Association of USAF Reserve Flight Surgeons

Factors to consider:

- We have many common interests
 - flight surgeon education
 - recruiting and retention
- We also have significant differences
 - State mission, responsibility to State HQ
 - may get more involved with Military Support of Civilian Authorities
 - ANG FS's under direction of ANGRC, the Air Surgeon
 - Tradition, history, banquets
- Merger might make the meetings too large, unwieldy
- Hard to ignore the competition between ANG and AFRC with regard to R&R

Proposals:

1. Recognizing that we are a distinctive culture that will not readily be absorbed into a homogeneous ARC without losing valuable unique contributions, the committee recommends that the Alliance explore ways to work more closely with the Association of USAF Reserve Flight Surgeons, but retaining our separate organizations. We support efforts to expand our alliance with our counterpart ARC organizations.
2. The committee recommends that the Alliance propose the creation of a system that allows essentially transparent transfers within the ARC (ANG and AFRC), with minimal paperwork, no hassles, delays, etc.

Discussion:

1. ARC: The AFRC will never have the state mission of the ANG. The two organizations have differing traditions and history. This will probably always prevent the assimilation of the ANG and AFRC into one seamless ARC.
2. Easing the transition between AFRC and ANG might be part of a larger system (compare Palace Chase) that eases transitions from AD as well. It could include the IMAs, too. An AF-wide medical asset tracking/assignment system could also more readily accommodate the many physicians who find themselves changing their civilian status (completing residencies, moving around the country, etc).
3. We can always improve the alliance (lower case A) of the Alliance with our counterpart ARC organizations, without a frank merger (common officers, merged treasuries, etc)

Issue: Medical Systems Council**Factors to Consider:**

- This committee is only ad hoc, will formally disband upon completion of its report at AMSUS-99
- Expansion of the concept of this committee to include representatives of the other corps would give it more widespread support
- There are already some mechanisms for getting word from the trenches to the senior leaders; we don't want to offend them
- Coordination with these various groups can be improved

Proposals:

1. The committee recommends that a Council (perhaps called Human Weapon System Council), modeled after the Weapons System Councils that exist for the ANG, be created, to include

- Presidents of the ANGMS Constituent Organizations
 - State Air Surgeons Society
 - Alliance of ANG Flight Surgeons
 - Academy of ANG Dentists
 - Association of ANG Nurses
 - ANG Optometric Society
 - Society of ANG MSC Officers
 - Also BSC and PA organizations if they form up
- ANG Medical Assistants
- NGB/SG, ANGRC/SGPA
- ? others

This Council might function on the web as this committee has done, to discuss current concerns in a timely manner, and coordinate responses.

2. This committee also recommends that a flight surgeon or two be added to the existing Weapons Systems Councils if possible.

Discussion:

Although the Alliance has taken the lead on this issue with this Strategic Planning Committee, it is important to be inclusive, especially in this era of corps-neutrality. The Weapons Systems Councils try to gather the most experienced pilots, etc in each aircraft, and cross-pollinate. A most useful factor is the timely exchange of info with this network, so that corrective actions can be taken as various threats arise (everything from maintenance to funding). These councils are a great model for the ANG Medical Service to emulate.

Meanwhile, there are already Guard-wide councils for each weapons system (i.e., each airplane). Adding a flight surgeon or two to these councils seems like a natural idea, especially as the pilot-physician program has not expanded to the Guard. These councils need the input of flight surgeons to add the proper considerations for the human system.

Reminder: Our Alliance Constitution states that we exist

A. To contribute strong support to the overall mission of the Air National Guard and the United States Air Force; develop a Mission-oriented philosophy of the membership; and delineate to commanders the benefits of the professional contributions to them in the above mentioned mission.

B. To support the continuing advancement and development of the art and science of medicine throughout the Air National Guard and the United States Air Force; to encourage dissemination of the knowledge and experience gained through over all investigation of medical problems related to flying, missile and space operations.

C. To encourage and implement the training and continuing education of all members of the Air National Guard and the United States Air Force Medical Team; to support and implement the total force concept, and to encourage young physicians in a career of aerospace medicine and for their board certification in that specialty.

D. To encourage new physicians, nurses, dentists, basic science personnel, and Medical Service Corps personnel to become Career Guardsmen.

E. To encourage members to develop the highest standards of practice of Aerospace Medicine and its related fields.

F. To recommend to the Air Surgeon, National Guard Bureau, appropriate means for the enhancement of the career and practice of Aerospace Medicine and related fields in the Air National Guard and the United States Air Force when indicated.

G. To encourage professional relations between the membership and flying personnel of the Air National Guard, the United States Air Force, other military services, the civilian flying population, appropriate governmental agencies, and the aerospace industry; to endeavor to increase the military and civilian awareness of the high levels of medical professionalism maintained by all elements of the health care team in the Air National Guard and the United States Air Force.

H. To promote through concerted effort with the Air Surgeon, National Guard Bureau, the coordination of facilities and personnel in such a manner so as to properly support the Air Surgeon in the accomplishment of his duties.

I. To strengthen the sense of camaraderie and social exchange between the membership to increase the solidarity of the Alliance in support of the Air National Guard and the United States Air Force Missions.