Sixty Years

This year the Air Force will celebrate 60 years as a separate armed service. It is likely that in 2007 my time in the uniform will end after almost 35 years, so I will have been around for over half of the USAF’s existence.

Change—transformation—abounds. AFSO 21, Lean Six Sigma, recapitalizing, you name it. The CSAF wants every airman to be AEF participatory and deployable—not the 85% that are presently so qualified. Air Force personnel strength decreased over 16,000 this year and is projected to reduce by another 40,000 by 2009!

The USAF medical service is looking at a reduction of over 20,000 positions, and both the AFRC and ANG medics are experiencing losses of personnel.

Despite force reductions, our missions have increased. The ANG is the primary provider for an EMEDS in the OIF AOR beginning January 2007, and as we know ANG medics are the sole provider of CERFP and HLS medical response at this point. Furthermore, the USAF medics and the ANG medics are looked upon as leaders in “lean” operations and Expeditionary force structure. I have been in briefings in front of the Air Force Council and proudly watched as the 4-stars and civilian leadership were briefed on our successes.

I don’t know how much better we can get, but I am confident that we will. Just as I think we have become as lean and as capable as we can possibly be, something happens to further impress me and other leaders with our extraordinary talent. How we do this is exactly that—the talent of our amazing professionals! This nation is blessed with an exceptional array of superbly qualified and dedicated military medical specialists, and it is my great honor to be viewed as one of them.

You can bet that I will tell that story at every opportunity; you deserve nothing less.

Gerry Harmon
Major General
September 2006

From the pen, ANG Assistant to ACC Surgeon General
BrigGen Ray Webster

Fall is on the horizon and most of the summer Active Duty PCS/Retirements are in the books.

Brigadier General Russ Kilpatrick retired as the ACC/SG on September 7th in a memorable ceremony at Langley AFB. On September 8th, Brigadier General Tom Travis was in place as the new ACC/SG. In addition, Colonel Ken Knight is now on board as the new ACC/SGP. Ken will be looking for ANG Flight Surgeons to help with accident investigations and deployments. Let me know if you are interested and I can arrange to get you in contact with Ken.

Readiness Frontiers the first two weeks in August at Snowbird Resort, Utah were absolutely outstanding. From the EMEDS set up with a mass casualty exercise, Harvard trauma training, and RSV training for Flight...
Autumn 2006

TUESDAY, 9 November 2006

12:00 p.m. - Air Force Reserve Aerospace Medicine
12:00 p.m. - Welcome
12:45 p.m. - Bing Gen Chuck O'Toole, USAFR, MC
1:30 p.m. - Col Maria Pans, USAFR, MC
2:15 p.m. - Lt Col Richard Gist, USAFR, MC
2:15 p.m. - Travel Medicine: Med Intel Review
2:45 p.m. - Lt Col Richard Gist, USAFR, MC
2:45 p.m. - Break
3:00 p.m. - Travel Medicine: Food & Water Vulnerability
3:45 p.m. - Lt Col Haley Hughes, USAFR, BSC
3:45 p.m. - Human Performance Enhancement
4:30 p.m. - Col Susan Northrup, USAFR, MC
4:30 p.m. - Occupational Medicine
5:15 p.m. - Col Brent Klees, USAFR, MC
7:00 p.m. - Association of USAFR Flight Surgeons
9:30 p.m. - Annual AMSUS Social
Rivercenter Comedy Club
549 E Commerce, San Antonio

WEDNESDAY, 8 November 2006

7:15 a.m. - Air Force Reserve Aerospace Medicine
5:30 p.m. - Convention Center, Room 205
Moderator:
Lt Col Leah Brockway, USAFR, MC
7:15 a.m. - Welcome
7:30 a.m. - Lt Col Leah Brockway, USAFR, MC
8:15 a.m. - USAFR
8:15 a.m. - Lt Gen James G. Rosedale, USAFR, MC
9:00 a.m. - AF Reserve
9:45 a.m. - Col James Collier, USAFR, MC
9:45 a.m. - Col William Hend, USAFR, MC
10:00 a.m. - Award Presentation
10:00 a.m. - Brig Gen Charles O'Toole, USAFR, MC
10:00 a.m. - Brig Gen Robert Lance Chu, USAFR, MC
10:30 a.m. - Aeromedical Summaries & LOD
11:15 a.m. - Col Susan Northrup, USAFR, MC
11:15 a.m. - Lt Col Steve Bell, USAFR, MC
11:45 a.m. - Formal Training Access
11:45 a.m. - Mr. William Waterman
12:00 p.m. - Lunch
1:30 p.m. - Annual General Membership Meeting
3:30 p.m. - Association of AFR Flight Surgeons
3:00 p.m. - Psychological First Aid for the Flyer
3:45 p.m. - Maj Denise J. Thompson, USAFR, BSC
3:45 p.m. - Gap Analysis: How to do it
4:30 p.m. - Col (Ret) Roddie Vanderbeck, USAFR
4:30 p.m. - Critical Care Management: Review & Update
5:15 p.m. - Col (D) Michael Siggel, USAFR, MC

Articles and announcements for the next newsletter should be submitted by 1 May 2007 (but I will be happy to accept them anytime before then.)
Avoid the last minute rush; submit your article today.
Once again, authors, thanks for the great contributions—WWP, editor)
**From the pen of the AANGFS President:**

The *flight surgeons* of the Air Reserve Components—Guard and Reserve continue to **demonstrate their indispensability** to the mission of the Air Force in these exciting times.

Deployments in support of the **War on Terrorism, humanitarian assistance** at home and abroad as well as **keeping our war-fighters fit to fight**—all ongoing efforts that would not be possible without you.

The AANGFS and AFRFSA continue to give excellent value for the members by providing timely, thorough deployment required RSV training. The associations also are a forum for exchange of information and feedback for leadership.

**Kudos** to the office of the USAF Surgeon General for developing a standardized *Flight Surgeon Aircrew Qualification Examination* (see below) rather than relying on numerous local units to develop their own. The flight doc expertise in flight physiology and human performance span the breath of aircraft, yet the principles are the same. Completing this examination will allow portability of the flight surgeon examination.

This is a review of important information of which flight docs should be ever cognizant. **Throughout this issue, there are pearls of wisdom in red.**

Membership in the AANGFS is robust, finances are sound, and the educational program is excellent. Thanks for the opportunity to be your President!

**Bill Pond**

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**Flight Surgeon Aircrew Qualification Exam**

**Type:** Self-paced  
**Format:** SCORM  
**Cost:** $0.00  
**Provider:** Air Force Surgeon General Office

**Background:** This course consists of a Master Question File (MQF) of approximately 70 questions developed to reinforce and evaluate Flight Surgeon knowledge of aircrew requirements and core aeromedical competencies directly related to aircrew performance. Completion of this test is required every 17 months to meet criteria for Flight Surgeon aircrew qualification written testing as outlined in AFI 11-202V1, Aircrew Training, and AFI 11-202V2, Aircrew Standardization/Evaluation Program, and replaces previously mandated, unit-developed, MDS-specific Flight Surgeon tests.

**Overview:** This is a self-paced, web-delivered test. Text and hyperlink references support the examination of which flight docs should be ever cognizant. The association also provides a forum for exchange of information and feedback for leadership. **Kudos** to the office of the USAF Surgeon General for developing a standardized Flight Surgeon Aircrew Qualification Examination (see below) rather than relying on numerous local units to develop their own. The flight doc expertise in flight physiology and human performance span the breadth of aircraft, yet the principles are the same. Completing this examination will allow portability of the flight surgeon examination.

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**Bill Pond**

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**Roadmap to Access/Navigate Online Flight Surgeon Aircrew Qualification Test**

1. Go to AFIADL website:  
   [https://afiadl.mont.disa.mil/](https://afiadl.mont.disa.mil/)
2. First time users click on Register to follow instructions to establish login and password.  
3. Enter login/password and click Submit.  
4. Click on Learning Center.  
5. Click on Course Information and Enrollment.  
6. From pull-down menu in the top right corner labeled Topic, scroll down and select Medical then click on Search.  
7. Click on Flight Surgeon Aircrew Qualification Exam.  
8. Read Course Description: Background, Overview, and Assessment.  
9. To take the qualification test, click on Take Course (**NOTE:** Ensure box is checked next to Take Course for Credit), and then Flight Surgeon Aircrew Qualification Exam. The program will generate 30 questions from the MQF that will cover all major subject areas.  
10. Answer all 30 questions. The majority of references are hyperlinks to the appropriate documents. Upon completion click Submit.  
11. Upon course completion, click on Personal KC on the left side of the screen.  
12. Within the Personal KC window, click on the Transcript tab along the top.  
13. If you have successfully completed the course a certificate hyperlink will appear next to the course name. Click on this hyperlink to go to a printable version of the certificate.  
14. Provide a copy of the certificate to STAN/EVAL who are responsible for providing this documentation of test completion to your local HARMS office for inclusion in your Flight Record.  
15. For any questions, or suggestions for additional test content, please contact AFMSA/SGPA, Operational Medicine at DSN 297-4200, or the AFIADL Support Desk via the link on the left side of the AFIADL webpage. (This is a great idea, a little bit tricky to navigate, but definitely worth the effort—WWP, editor.)

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***Crewmembers will not be scheduled to perform crew duties within 72 hours after loss of 200cc (standard blood donation) or more of blood. For aircrew on mobility status, or subject to on-call alert duties within the above timeframe, they must first get their flying unit commander’s approval before donating blood.***
The Final Frontier

Maj J. D. Polk

You would have to have been living in a cave for the last decade to not notice the sudden interest in Space Tourism. A quick web search of the term “Space Tourism” will tell you how many new start-up companies are vying for pole position since the X-prize was won. Space planes are being designed right and left, and some even “borrow” from the old Air Force X-20 design. Russia and China have both been working on space plane designs. Both have their space programs intricately tied to their military. The future of mankind, business entrepre-

neurship, and old fashioned capitalism are definitely tied to space.

But the United States military was recently hammered for not doing enough in space, with threats of splitting space off into a separate service or space force if change did not occur. The Air Force and the other military services set about to develop their space cadre in response to the scathing report by the Commission on Space.

Most of you who know me, know that I am indeed a space cadet, both literally and figuratively. As the Chief of Medical Operations at NASA, I lead one of the most highly educated and highly trained flight surgeon cadre. There are 12 reserve flight surgeons and 2 active duty flight surgeons at NASA Armstrong Operations Headquarters. Unfortunately, most of the military has no idea we even exist, or that our expertise in space is beyond the “turn your head and cough” examination of the astronauts. But there is much more to it.

It is Saturday, the 9th of September 2006. I am in the Launch Control Center (LCC) at the Cape representing the Medical Operations Branch. The Neutral Buoyancy Lab with them, lifting weights and taking care of their families. We have been working on the new Orion Spacecraft for the past year.

The President and the Department of Defense have called for the training and development of a cadre of space professionals. The expected specialty codes of systems procurement, space weapons operators, and satellite drivers are already included. What has been forgotten is the identification of the unique medical skills necessary to crew some of these professionals, the military Astronauts who fly currently in the civilian space program, those that will fly in the next generation of military aerospace vehicles, and those who can best utilize the orbital technologies and capabilities that only space medicine can provide. But medicine is never considered in the space cadre, or at least it hasn’t been yet. Sure, there is a mention in the rules, but will it stay that way? We believe we already have both an experienced cadre of military space medicine professionals and the training programs to continue to produce more.

I sincerely doubt that Virgin Galactic will be sending folks to space in a space plane and the Air Force will have to worry about the operations. But will it stay that way? We believe they already have both an experienced cadre of military space medicine professionals and the training programs to continue to produce more.

If the Air Force suddenly has a change of for- heart and realizes the value of having medical officers as space cadre, they will then have to come grips with the fact that an enormous amount of training goes into it. It isn’t something you can pick up as you go along. We fly, we dive, we know space physiology, we know engineering subsystems, we know human systems integration, we have to learn Russian, we have a plethora of things to learn in order to be corps as space cadre, they will then have to come grips with the fact that an enormous amount of train- ing goes into it. It isn’t something you can pick up as you go along. We fly, we dive, we know space physi- ology, we know engineering subsystems, we know human systems integration, we have to learn Russian, we have a plethora of things to learn in order to be
there is the Aerospace Medicine in Space Operations course. This course was held every other year at Brooks City Base, but I am not sure of the fate of the course at this time. There is also the Space 100 course from the National Security Space Institute.

Much as some flight surgeons sport jump wings in addition to their flight surgeon wings, I hope in the future we will have flight surgeons sporting space wings. It will take a changed mindset. But space is here to stay, and as flight surgeons, we will always have an important part to play in the final frontier.

T minus 9 minutes and counting...

**Update from Headquarters**

First of all, I’d like to thank each and every one of you for what you do for the Air Force and for this country. In these hectic and fast-paced times, it may not feel like you are getting the recognition you deserve for your hard work and dedication but, believe me, we notice and we really are thankful that you are doing such great things! Secondly, I’d like to thank General O’Toole for this opportunity to communicate with all of you via this newsletter. Thirdly, and before I get into the real gist of my information to you, I want to remind you that no one deserves for your hard work and dedication but, believe me, we notice what you do for the Air Force and for this country. In these hectic and fast-paced times...

**Air Force Certification Criteria to be Space Cadre and Wear the Space Badge**

<table>
<thead>
<tr>
<th>Level 1 (Basic):</th>
<th>Level 2 (Senior):</th>
<th>Level 3 (Command):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education: Space 100</td>
<td>Education: Space 200; Continuing Education</td>
<td>Education: Space 300; CCAF; Continuing Education</td>
</tr>
<tr>
<td>Training: Current in position; CDC(5-level) complete</td>
<td>Training: Current in position</td>
<td>Training: Current in position</td>
</tr>
<tr>
<td>Experience: 1 year in a space billet</td>
<td>Experience: 6 yrs in space billets</td>
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</tbody>
</table>

**NASA Flight Surgeon Requirements to be Certified**

| Education: MD or DO degree, Master’s Degree in Aerospace Medicine, Space Studies, or Aerospace Engineering |
| Training: 540 hours for shuttle and space station |
| Experience: Board certification, ACLS, ATLS, 50 hours CME in aerospace per year, practice experience, 2 years OJT |
| Dive certification |
| Flight qualification in T-38N |
| United Space Alliance Academy training |

**Comparison of Air Force criteria for wear of the space badge by space cadre with requirements and training received by Active Duty and Reserve flight surgeons at NASA**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Active Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training: Current in position</td>
<td>CDC(5-level) complete</td>
</tr>
<tr>
<td>Experience: 6 yrs in space billets</td>
<td>1 year in a space billet</td>
</tr>
</tbody>
</table>

There are lots of new developments at the HQ staff that we hope will make you more effective as ARC flight surgeons. First, we are continuing to work our transformation that will enable us to support the new enroute care mission of the Air Force Medical Service but will see us divest ourselves of our pure EMEDS mission. Even though this will eliminate some flight surgeon slots that currently support EMEDS, it is countered by new base operating support UTCs, so the overall effect on flight surgeon billets is negligible. The actual tasks that flight surgeons perform while deployed will not change so all of you will still be doing outpatient medicine, human performance preservation, preventive medicine and aeromedical evacuation support.

Secondly, there are a lot of new policies that have come out recently so make sure you are up on all the changes. As you may remember, the new AFI 48-101 came out in August of 2005. Hopefully you have had a chance to implement those requirements that were missing. The IG has unfrozen the operational support items so you will now be graded on those operational support activities that are at the heart of what we do as flight surgeons. Flying, shop visits, safety briefings, and occupational medicine are now “officially” as important as all the PHAs and other tasks you are required to accomplish. Your chief of aerospace medicine should be working with you to help prioritize your tasks if you are in one of those common situations of having more work to do than you have time. We added a new section to the SGP policy memorandum that went out in September of this year that helps clarify the requirements in 48-101 for AFRC which we hope will make it easier for you to comply with 101. Speaking of the new policy memorandum, it also has supplemental guidance on the new AFI 48-123 which just came out. The biggest change is in mental health standards. As a reminder, AFRC no longer uses medications as the determinant on qualification for world wide duty. If someone has one of the few mental health conditions listed in the AFI they will need a world wide duty (WWD) evaluation. Any other axis one diagnosis requires an assessment by a military mental health provider for deployment suitability. If they are cleared to deploy, no WWD evaluation is required.

Modafinil is now approved for all aircrew that are allowed to use go pills. This is a significant expansion of our armamentarium to help maintain aircrew performance. Those of you who support CAF units need to be well versed on the side effect profiles and other advantages of Modafinil over Dexedrine so that aircrew can make an informed decision about which, if any, go pill they wish to use.

As you know, commanders must now approve all 4T profiles before they are loaded into MilPDS. We have purposely left the mechanics vague initially so that each base could implement a system that made sense for them until such time as we are able to put a system wide solution in place. If you need advice or help figuring out how to implement the CSAF’s new profiling policy, please call our SGP office. They are more than willing to help you work through this important process.

Finally, let me commend all of you for helping clear up the backlog of line of duty (LOD) cases on our Reserve members. The medical units have been doing a great job processing the cases and the new LOD module in RCPHA show us that your turnaround time is usually the shortest of those players involved at the wing level. We are hoping to shorten the process by several steps with the new LOD AFI. In the mean time, do what you can to help your commanders and JA folks get the LODs completed in a timely fashion.

Again, thanks for all you do and my staff and I are looking forwarded to continued opportunities to work with and for you!

*Jim Collier*
I don't have to tell you that you flight surgeons are the backbone of our units that provide base operating support (BOS). I know the work never seems to end and getting it right is tedious but without you, our flyers wouldn't be able to deploy and carry on the flying missions. You're all volunteers and I'm proud of the dedication and sacrifice you make. Many of our civilian colleagues can't understand why we do this because it costs us in terms of lost time. Many of our civilian colleagues can't comprehend how some of us are getting along in years. We have some units that have been struggling to get flight surgeons. When we go out on our visits to the units, we see how some units are struggling and have to rely on the active duty to get their physicals done and watch over their flyers and support shops. I need you to become our spokesmen and recruiters for new flight surgeons. You need to think globally about how we can help each other in the NAF to get the job done. In other words, I would like to see you guys start thinking beyond just your units. Meet the other NAF flight surgeons in your region. Share your ideas about how to work your programs more smartly. If you know a unit is short or doesn't have a flight surgeon, tell them that you are a member of the Reserve Flight Surgeon Association and they should know. This is the least you can do. As you know, our numbers are small and some of us are getting along in years.

Our new SGP is Lt Col(s) Art Nuval from the 452 AMDS, March ARB, CA. He is excited to have joined us and we are glad to have him on board. A lot of you already know who he is, so don't be shy about congratulating him on the move, and then hit him with your tough issues. He's had a lot of experience. He was mobilized for 1 year for BOS at the 452 AMDS, has been an SGP for 4 years, and has worked at the active duty flight surgeon office at the LA Air Force Base. What he doesn't know, he'll research for you. I expect that you'll keep him busy. He's had a lot of experience and documented. I'll leave it to you to come up with solutions, but for those of you who will be facing an upcoming HSI don't be surprised if this comes up along with the question about how your are documenting that you are making an aeromedical disposition every time you make an entry on the SF 600 for a flyer. Call us if this doesn't make sense to you.

Lastly, again, thanks for all you do. I look forward to seeing all of you in future travel.

Bruce L. Nelson, Col, USAFR, MC, FS, Chief Medical Division, 4 AF/604 RSG/SG
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Letter to the Editor
from Col(ret) Phil Steeves
Interesting excerpts from two early articles related to the first opinions of what we would call flight surgeons, and their impressions of (fighter) pilots.

1) Rippon & Manuel, September 1918, The Lancet, Report on the essential characteristics of successful and unsuccessful aviators:

- Hands. - One of the most important characteristics we have noticed in successful aviators is "hands." This characteristic is difficult to define, but may be described as follows. The horse-rider with good hands is able to sense the mentality of a horse by the feel of the reins and also to convey his desires accurately to his mount. We have never known of a man who has consistently been in the first flight in the hunting field making anything but a good pilot.

"Hands" appear to be congenital and cannot be acquired, although they may be improved and vice versa.

2) G A Sutherland, December 1918, The Lancet, Observations on the medical examination of aviation candidates:

Among other things Drs Sutherland and Rippon, and LT Manuel, also noted that:

- The successful aviator possesses resolution, initiative, presence of mind, sense of humour, judgment; is alert, cheerful, optimistic, happy-go-lucky, generally a good fellow, and frequently lacking in imagination;
- Their favours"amusements include "music (chiefly rapturism);
- It appears necessary for the average pilot that he should indulge in a really riotous evening at least once or twice a month;
- They possess in a very high degree a fund of animal spirits and excessive vitality;
- It is not necessary to legislate on the subject of alcohol for pilots;
- The majority of successful pilots are unmarried;
- A persistent dilatation of the pupils with an excitable manner is regarded as suspicious of undue nervous excitability;
- If, for instance, we take the public-school boy who has been captain of his football team and has held his own in the class-room, we require no elaborate examination with special tests to estimate his physical fitness for flying;
- The rest is guess work;
- Instead of endeavouring to standardise the tests I think that an attempt might be made to standardise the examiners;
- Of being an aviation medical examiner ... we had no guiding principles and the problems set were entirely new;
- It may be said that the candidate will conceal important facts in his application and the problems set were entirely new;
- It may be said that the candidate will conceal important facts in his eagerness to be passed, and many do.

(Phil, great to hear from you. This is one article to post in the flying squadron break room—WWP, editor)
AFSO 21......“Lean Across the Air Force”

In a November 2005 memorandum, the Chief of Staff and Secretary of the Air Force explored the Total Force, top to bottom, to institute a comprehensive strategy to improve work processes. This predominant strategy will rely on the “Lean” concept, which includes “the two predominant process attributes of doing it right the first time, as well as to stop doing non-mission critical tasks, and the more material related reduction of desk, stock room, and warehouse related inventory”. This fundamental change in Air Force culture requires that all Airmen understand their individual role in improving their daily processes and eliminating things that don’t add value to the mission.

The “Lean” concept based on the book Lean Thinking by James Womack and Daniel Jones, began as a way to identify and remove production waste to gain competitive advantage. But, managers accustomed to thinking Lean noticed that other areas of the enterprise could benefit from Lean initiatives. They realized that cross-functional information flows were far more complex than they had to be. Too many steps were needed to manage and control processes and, ultimately, the organization as a whole. By applying Lean principles, routine business operations could be simplified, more rational procedures established, and repetition reduced (if not eliminated), thereby accelerating core business processes and responding more quickly to customer needs.

The Lean process has been proven in our Air Logistics Centers and some Maintenance areas over the last 4-5 years. Ergo, the entire organization can also benefit. AFSO 21-Air Force Smart Operations for the 21st Century, embracing the Lean concept, is the overarching program guiding continuous process improvement in the Air Force. It can be successfully applied to any process in the Air Force including the provision of in-garrison and operational flight medicine services.

I encourage all of you to become familiar with Lean and AFSO 21 by securing a copy Lean Thinking and reading about AFSO 21 on the web at http://www.afso21.hq.af.mil. It appears that this process is more of a permanent cultural change in the Air Force way of doing business than TQM was.

G.L. Bondar
Col, USAFR,MC,CFS
Chief, Medical Division
622 RSG/SG, 22AF

10AF's submission.
Hello from 610RSG/SG. Those AEF’s keep rolling around and the volunteer’s continue placing AFRC out front setting the standard for others. It is an honor to be associated with the people who repeatedly perform at such a high level and do so willingly. All continue while sacrificing at home. My hat is off to them.

Since transferring from the Army in 1992, the F-16 has been the primary airframe and airmen I have served. Like all of us, I have been afforded opportunities to ride in a ride a large variety of other airframes and experience some part of the day to day life of airmen in other units. For the past two weeks, I have been experiencing some of what is the day to day life a CCATT team member. They are also a special people. As I train to become qualified as a team member and serve with them on AEF’s, I know it gives me further insight to be better qualified to serve them as a flight surgeon. For those of you like me who have not previously been with them on an flying mission, even a training mission, I would encourage you to look for an opportunity to go on one their flights as a flight surgeon.

If you were wondering, I will still be at the 610RSG as the Medical Director while doing some CCATT missions. In that regard, a heads up on some recent memos and AFIs. AFRC has updated the approved medication list this past spring. There is a new AFI for incentive, fam or the like flights. I encourage each of you to read it and then get with the line side to give input on your local unit’s operating order. It is an opportunity to have included additional required processes for screening people medically on whom you may otherwise have limited information before you see them shortly prior to their flight. If you would like to discuss this further, shoot me an email at thomas.walker@charter.net.

Col Thomas Walker

**Crew Resource Management (CRM) as outlined in AFI 11-290 is intended to maximize operational effectiveness and combat capability while preserving resources. As such, the CRM Core Curriculum includes Situational Awareness, Crew Coordination/Flight Integrity, Communication, Risk Management/Decision Making, Task Management & Mission Planning/Debrief.**

***Crew duty time period starts when the crew reports for a mission, briefing, or other official duty***
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Deployments

When my Chief of Aerospace Medicine, LTC Eric Kendle suggested that he and I volunteer for the surgeon’s UTC in the Baghdad EMEDS a few years ago, I was certain he had a yet-to-be-diagnosed brain tumor and offered to drive him to the hospital for a CT scan. The more we talked about, the more I realized that volunteering to support the operation in Iraq was the right action to take, for many reasons.

My ANG colleagues such as Col Bill Pond, Col Sal Lombardi, Col Brett Wyrick, Col Pat Aiello, LTC Kendle, Maj Duncan and a host of unmentioned others have been there and since accomplished remarkable achievements. I wanted to share my thoughts on deployments during a time when the ANG Medical Groups maybe asked to support AEF contingencies as our active duty forces, Guard and Reserve wear thin and weary.

I asked myself, “How do you want your ANG career remembered?” Did I want to be remembered for an Excellent on a HSI, or to have traveled to Alpena Michigan more than any other place in the world? Was I a Flight Surgeon in the Guard? Obviously not. We have an opportunity to directly impact and support the security of our country and our families, to do something truly patriotic that will be remembered. Do you have to have a 20 year Guard career pass you by and have nothing remarkable to account for it, to validate it? So Eric and I pressed on, jumped through the hoops it took to get permission and thereafter experienced the most rewarding time of our professional lives in a dusty tent city at the Baghdad Airport.

Most of our Active Duty contingents were from Travis AFB, and a few other guardsmen. We blended right in and became a family quickly. Tent city was popular and we shared our tents with rats, mice, scorpion and the infamous camel spiders. It was hot, dusty, and the food was marginal when it was good. The showers were a large Petro dish enclosed within an Alaska Shelter and after a while I realized that staying on Camp Sather made much more sense than traveling into the Green Zone during the summer heat to go for Fallujah in the fall of 2004. These 64 days were without a doubt the most memorable days of my surgical and professional career. I miss my 44th EMEDS family daily and in many ways long to be back there.

With that voluntary departure from my practice came a cost, and this is the primary purpose of my writing: to summarize the financial and emotional cost on a flight surgeon contemplating a lengthy deployment.

I sent a note to my referring physicians to let them know I would be away, for how long and for what reason. I requested a leave of absence from my local hospitals where I performed surgeries and asked to have my medical liability insurance pro-rated for the time I was gone. My local medical society paid my dues for that year. A nice supportive gesture, my friends, and my family were, for the most part, supportive. One of my partners commented that would require him to make more call, and I recall that I was somewhat incensed when I heard that, but let it go. My wife’s wasn’t thrilled and in many ways scared for my safety. I remember doing the attack Intel on BIAP and while it wasn’t like Balad Air Base, they still had their share of IED and rocket attacks in the area. You can die crossing the street in Tucson as easily I thought and tried not to think about that too much. My friends had a huge party for me and the day I left I wanted only my wife and 2 sons to go with me to the airport. It was personal and private then and I didn’t want to share that time with anybody else. When I got there it was almost a movie-like environment. It was live-fire and there were loaded and the guys not actors. We suffered a 122mm Soviet-made rocket attack the morning I got the Baghdad, which impacted coincidentally within an Alaska Shelter and after a while I realized that staying on Camp Sather made much more sense than traveling into the Green Zone during the summer heat to go for Fallujah in the fall of 2004. These 64 days were without a doubt the most memorable days of my surgical and professional career. I miss my 44th EMEDS family daily and in many ways long to be back there.

I estimate that the for the time I was gone I sacrificed over $100,000 of billings per month, which equated to about $30,000 of earnings a month. I still had my practice bills to pay, employee’s salaries, etc. My overhead continued and I had no type of insurance for that. My practice did have an extended absence clause that stated after 30 days, that some of the costs would be forgiven, in case you suffered a prolonged illness or injury for example and could not work. That was very helpful to me for the 2nd month away. When I got ready to come back I had my office manger send all of my referring doctors a note, telling them I would be back in 3-4 weeks and it was okay for them to start referring, but if they chose to do so. I was saddened and had my eyes opened when I came to find that many of my regular referring docs forever changed their referral practices, not because of me personally, but because habit patterns are hard to break. I am not the type of person that will cold call a doctor to ask or beg for a return of their surgical referrals. Many of my regulars were glad to see me back and I had a good start when I got back. I would say my practice never fully recovered from it, but it did recover to an ap

I tried to reinforce the fact that no U.S. servicemen have been injured at Camp Sather for quite some time and that if they stayed on the Camp and elected not to take tours of downtown that they had very little to be truly concerned about. Some of my folks are single parents and have child-care issues to attend to, but we are already supposed to be prepared for such possibilities. The financial concerns I have already mentioned and they, in my opinion, are the most genuine of concerns. Each of us will have to deal with and justify those costs in our own way. I am certain that your combat pay won’t make up the difference so you will need to be prepared. Personally, I think it was well worth the cost/ sacrifice whatever you want to call it. And I would do it again, knowing it would hurt a little financially within my household and that my practice may take another direct hit to the referral magazine.

In summary, if your country calls on you, how will you respond? Those like Lombardi, Kendle, Wyrick, Pond, Duncan and many others that called and I am certain will tell all that the experience was one of the most memorable in their careers and one they secretly miss and aspire to enjoy once again. Personally I would feel my Guard career was complete if I could take my well-trained medical group personal to Baghdad and have them participate in something for real, something other than an Alpena exercise or Code Silver (not those training vehicles are not important mind you), and have them take home with them something that they will be proud of for a lifetime, something that will validate their careers. So if you think you cannot do this, I say you can. But realize those of us who support this possible mission also remember that it is not as easy as it may sound, and that there exists real family, financial and practice aspects to consider. I can leave my Guard career at this point and be whole. I made the almost 20 years of what seemed to be the most monotonous training, become immediately the most valuable. So if we are tasked, let’s do with enthusiasm and do it right. We can work together and make it a survivable request on many levels.

The last time I submitted an article to this newsletter was many years ago and the topic I addressed was PM and how I thought AWC and PME for the drill status guardsman was excessive and unnecessary. How times have changed. I completed AWC 5 years ago, and appreciate the experience and what I learned and the credibility it now gives me with my wing leadership…so I was wrong about that too. We do work hard and do we get all of the credit that we deserve for what we do in our private practices? Probably not.

Jim

Jim Balserek, Col, MC, CFS
Commander 162nd MDG
Tucson AZANG

(Jim, thanks for an insightful article that puts the deployment issue in perspective—WWP, editor)

Col James Balserek and wife Kristi with the President Bush

Everything a commander needs to know in only 1 week/month. It is impossible and you commanders out there know that to be true. We are a dedicated group of citizen soldiers and we do this most of the time, because we like it and we know it serves our patriotic duty, not because of fame or fortune, nor any expectation of career advancement.

As there are more and more discussions of the ANG MDGs supporting the EMEDS at BIAP, one of major issues to be discussed is for deployment length. Personally, I think if the ANG took a 120 day AEF and supported it in 3 by 40-45 day cycles that it would solve problems immediately. Many argue we cannot be effective in a shorter period of time. I say, I was effective within hours of boots on the tarmac at BIAP, was processed in a matter of hours and working within 12 hours of landing. It took 36 hours to get there from Tucson. But dividing the 120 AEF into 2 by 60 day rotations seems to be what the higher-ups want and to that I would concede. But, I think a physician would secretly say that 30-45 days would be much easier on their practices than 60-120 days, and that point I personally understand and respect. So when I sat in on MG Harmon’s address to the State Air Surgeons at Readiness Frontiers and heard the numerous concerns about not being able to support the BIAP EMEDS mission, I both agreed and disagreed with the arguments at the same time.

It is in no way an easy situation for traditional ANG Medical Groups, but I do think if we are tasked, we need to find creative ways to support that effort and even more creative ways to motivate our colleagues who may be understandable concerned and fearful of the consequences of leaving practices they worked so hard and maintain.

If you are reading this and thinking, “Still, I know I cannot personally do this. It is too much,” I would tell you I felt the same way initially, but you can and you will be a better person in many intangible ways for doing so. I asked my Medical Group personnel about their primary concerns of such a deployment and there responses in order were:

Fear
Family
Financial

I tried to reinforce the fact that no U.S. servicemen have been injured at Camp Sather for quite some time and that if they stayed on the Camp and elected not to take tours of downtown that they had very little to be truly concerned about. Some of my folks are single parents and have child-care issues to attend to, but we are already supposed to be prepared for such possibilities. The financial concerns I have already mentioned and they, in my opinion, are the most genuine of concerns. Each of us will have to deal with and justify those costs in our own way. I am certain that your combat pay won’t make up the difference so you will need to be prepared. Personally, I think it was well worth the cost/sacrifice whatever you want to call it. And I would do it again, knowing it would hurt a little financially within my household and that my practice may take another direct hit to the referral magazine.

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Ballistic Protective Eyewear

As body armor has become more readily available, survivability in the desert has increased. However, the incidence of devastating head and neck wounds has also increased. The majority of the head and neck injuries involve injury to the eyes.

Improvised Explosive Device (IED)-type weapons used in unconventional warfare by terrorists create serious threats. Fragmented, small ballistic projectiles are common with these weapons and pose great danger to our troops. Our Airmen were deploying with eye protection, but in retrospect, we have realized that a vast percentage of the protective eye protection was inappropriate.

Air Staff recognized the need to establish an Air Force-wide policy to ensure Airmen deploy with eye protection and that the eye protection can meet our wartime threats. The Air Force Protective Eyewear List (AFPEL) is the list of allowable eye protection devices.

There is no “best” product for all units. Units must determine if their members require spectacles, goggles or both dependent upon:

- Environment and risk of exposure
- Normal duties of the individual/unit
- Financial resources available

Becoming familiar with the product characteristics about each AFPEL item will assist you and the Unit Deployment Managers in choosing the product that will be unit appropriate.

1. ESS ICE 2/NARO

This is the system of choice for Airmen requiring vision correction and includes frame, clear and sun shield, neck leash and case. Prescription insert is ordered through the optometry clinic. The ICE 2 is designed for Airmen with medium to large faces while the NARO is for Airmen with very small faces.

2. Revision Sawfly

This eyewear is appropriate only for Airmen NOT requiring vision correction. The kit includes frame, clear and sun shield, and case. The product is “One size fits all”. Note that this is the most expensive BEP product on AFPEL. It is also very important that care is used when ordering. ONLY the military version of this frame that has the clip on the center of the bridge should be purchased. Other versions do not pass military ballistic testing. The National Stock Numbers should be checked very carefully.

3. UVEX XC

This device is appropriate for all Airmen and the kit includes frame, clear and sun shield, neck leash and case. The prescription insert is ordered through the optometry clinic and is available in two sizes:
- Regular for Airmen with small/med faces
- Large for Airmen with very large faces

4. OAKLEY SI M FRAME

This eyewear is appropriate only for Airmen NOT requiring vision correction. The kit includes frame, clear and sun shield, and case. The product is “One size fits all”. It is the least expensive BEP product on AFPEL. It provides exceptional facial coverage, but the assembly with insert carrier can be challenging.

5. WILEY X PT-1

This device is appropriate for all Airmen. It may be worn over Frame of Choice spectacles. The product is available in Olive Green.

6. ESS PROFILE NVG GOGGLE

This device is appropriate for all Airmen NOT requiring vision correction. The kit includes frame, clear and sun shield, and case. The product is “One size fits all”. It is the most expensive BEP product on AFPEL. It provides exceptional facial coverage, but the assembly with insert carrier can be challenging.

7. ESS LAND OPS GOGGLE

This device is appropriate for all Airmen. It may be worn over Frame of Choice spectacles. The product is available in Olive Green.

8. ESS VEHICLE OPS

This device is appropriate for all Airmen. It may be worn over Frame of Choice spectacles. The product is available in Black.

9. ARENA FLAKJAK

This device is appropriate for all Airmen. It may be worn over Frame of Choice spectacles. The product is available in Tan. NOTE: Fogging problems noted in field with this product. Due to quality issues, this product may be removed from future updates of the AFPEL.

***FYI: the use of contact lenses by aircrew is prohibited while wearing aircrew chemical defense equipment IAW AFI 11-301V1 and AFJ...
It is hard to pick which event to talk about for the 22nd Air Force this quarter. Each unit has had something significant going on.

This has been a quarter of recognition for the units that make up the 22nd Air Force. Recently, the Association of Military Surgeons of the United States selected seven units and 17 reservists as winners of Air Force Reserve Command's 2006 AMSUS awards.

We have also been neck deep in training. Somehow, between a visit from the President this month, Dobbins was engaged in some serious training for disaster medical support. They participated in a National Disaster Medical Service exercise. A practice of deplaning, triaging and tracking as many as 100 patients, agencies from the Georgia State Defense Force, Cobb County Public Health, Douglas County Public Health, Centers for Disease Control, American Red Cross, Metro Atlanta Regional Transit Authority, Federal Emergency Management Agency, Georgia Emergency Management Agency, local hospitals and units from around Dobbins received knowledge and training on what it was like to handle a hurricane disaster.

The 302nd ASTS also participated in an Air Medical Staging Exercise. This was on top of the constant stream of deployed personnel they have been taking care of.

The 403rd ASTS at Keesler has been in the midst of rebuilding and recovering from last years devastating hurricane season, but has been open for business and fully functional. Congratulations to our fellow association member Col Maria Pons and the 403rd for the excellent rating on their recent HSI.

Members of the 439th ASTS at Westover were deployed to Balad, and Kirkuk, where the action has not seemed to stop. The 440th ASTS has supported a steady stream of C-130's to Iraq. Meanwhile the 512th AW at Dover has taken possession of new C-17's.

One of the most important happenings has been the retirement of Chief Master Sergeant Dennis Kirkland from the U.S. Air Force, and the 910th Airlift Wing. Dennis spent 36 years in the service, with all but 2 of those years served solely with the 910th Airlift Wing. A 36 year career in the Air Force reserve. That deserves more recognition, more award, and more notoriety than any plaque or medal can give. This speaks a word with me when I was reviewing all the happenings within the 22nd Air Force because I know Dennis personally. Dennis had an impact on many officers and noncoms alike. He is a very personable and professional airman, and epitomizes the role of the Air Force reservist.

He knew everyone, and I mean everyone in the unit by name, and I dare say he knew almost everyone on the entire base. He also performed nearly every job on that base over his career. But he made the medical unit his home. He is a self-made man, and Air Force blue to the bone. Unlike many active duty bases, where people move about every 2 to 4 years whether they need to or not, reservists tend to stay at one base, and they tend to bond with their fellow reservists a great deal. It becomes more than just a unit, it becomes a second family.

The 22nd Air Force has a lot going on right now, with support of wars in two areas of responsibility, defense of the homeland, and training exercises going on incessantly. Somehow the 22nd Air Force will seem just a little smaller without Dennis Kirkland in it. Thanks for your 36 years of service Denny. May all of us in the 22nd have a career even half as fulfilling.

J.D. Polk, Major, USAFR, MC, FS
Chief, Aerospace Medicine
22nd AF/622nd RSG SGP
Chief, Medical Operations
NASA Johnson Space Center

As we prepare for our Annual Chapter Meeting during AMSUS (5 Novem-
ber 2006 in San Antonio, Texas), I recognize that many of you will not be in
attendance to hear the annual report. Therefore, I wanted to share some infor-
mation and gather your feedback......which I will then share with those in
attendance. I will also send out a follow-up e-mail after our meeting.

There are currently, three major areas of focus for the Society:

First, thanks to the hard work of retired Major General (Dr.) Dennis Higdon, our
guest lecturer for this year's meeting will be retired Lt General (Dr.) PK Carlton (former
USAF/SG and current Director of the Texas A and M Center for Homeland Secu-
rity). He will cast a vision that will inspire the Weaver Society regarding our capability
to shape the current environment regarding the Global War on Terrorism. Our current
membership serves as a wealth of knowledge, and we need to leverage that influence into partner-
ships that will increase our nation's overall readiness posture.

Second, we will spend some time at AMSUS discussing a new and revitalized strat-
egy to have Dr. Weaver posthumously promoted to the rank of Brigadier Gen-
eral. We have had great frustration over the last year and feel the process has been "stalled". We will overcome the resistance and will ask AMSUS to join the camp-
paign. We have complete faith that this process will eventually be successful!
WHY WE FIGHT

The title for this column comes from Band of Brothers, the episode when men of Easy Company come upon their first concentration camp at the end of World War Two. I had occasion to think of that phrase, when recently I was in New York for a conference. I had planned to attend advanced training for a new procedure, and had scheduled it so far in advance that I never even noticed that the first day of the program was 9/11. As I went through the day, memorial services abounded, and there were reminders of that day five years ago everywhere. I have to admit that as the day wore on I was having a tough time, until I looked up at a passing jet, and saw that it was a Viper – a Guard Viper on combat air patrol over New York.

Many people don’t know I’m originally from New York City – I grew up within walking distance of the World Trade Center and asked my wife to marry me at Windows on the World. Since 9/11 I’ve had the opportunity to deploy on several occasions, including to Ground Zero. Every time I need to be clear why I put on my uniform and take time away from my job and my family, I just have to remember walking through a 10 story high pile of smoking rubble that used to be part of my neighborhood, or the wounded troops on the airvac flights I’ve been privileged to fly on. We do this because we are taking care of our friends, our neighbors, our fellow countrymen. Our soldiers, airmen, sailors, and marines deserve the best care possible, and we are the ones who can provide it. What’s more, if ever there were a perfect opportunity to recruit new physicians, it’s the chance to provide state of the art care, to people who both need and deserve the best, and to work with some of the most talented and dedicated professionals on the planet. Where do I sign up?

Col Reid Muller

Attention Flight Surgeons.

A current RAM (and Guardsman) will be conducting a survey of Air Reserve Component Flight Surgeons looking at satisfaction, deployments, training and ops tempo. This is similar to, but separate from the FS Survey commissioned by the USAF/SG several years ago. The survey will be web-based and anonymous and should go “online” toward the end of October. Look for an e-mail and other announcements later this month for the web address. Colonel Riggins (NGB/SG) fully supports Guard Flight Surgeon participation and will be receiving the results when they become available. The POC is Major Lisa Snyder (lisa.snyder@brooks.af.mil).

(This is really important information for policy makers; please take a moment for your input, thanks—WWP, editor)
**RESERVE FLIGHT SURGEONS ASSOCIATION**

**ANNUAL AMSUS SOCIAL**

**When:** Tues, 7 Nov 06  
**Where:** Rivercenter Comedy Club  
849 E Commerce; Ste 893  
San Antonio, TX 78205  
(short walk from all convention hotels)  
**Time:** 1915-2200  
**Cost:** Members = free; Guests = $5  
**Reservations:** email Robert.Chu@pentagon.af.mil  
(pick up tickets @ Member Desk during Reserve AMSUS events)

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**05 NOV @ AMSUS for the Society of SAS**
- **0800-1200** SAS’s meet with Assistants. Advisors, and ANG/SG with additional attendance from EUCOM/SG and SOUTHCOM/SG  
- **1300-1700** SAS’s meet with EUCOM/SG, SOUTHCOM/SG and Army Guard Surgeons  
- **1800-1930** Reception sponsored by Society of SAS

The room assignment has been changed due to the fluctuation of attendee numbers—Please check upon arrival.  
**Col Jim C. Chow**  
President, Society of State Air Surgeons

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**FUTURE ANNUAL MEETINGS**

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<th>YEAR</th>
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<tr>
<td>2005</td>
<td>Navy</td>
<td>30 Oct - 4 Nov</td>
<td>Nashville, TN</td>
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<tr>
<td>2006</td>
<td>VA</td>
<td>5-10 Nov</td>
<td>San Antonio, TX</td>
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<tr>
<td>2007</td>
<td>Air Force</td>
<td>11-16 Nov</td>
<td>Salt Lake City, UT</td>
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<td>2008</td>
<td>USPHS</td>
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<td>2009</td>
<td>Army</td>
<td>15-20 Nov</td>
<td>St Louis, MO</td>
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**WSC meetings are on Tuesday, November 7.** We have time & rooms blocked for regions to meet among their own groups from 8-10, then an at-large meeting for regional leaders (and interested others) from 10-12. Hope to see you there!  
**MICHAEL PALETTA,** Colonel, MC, CFS  
Medical Weapons System Council

---

BGen Chuck O'Toole  
AFRC FS Association  
1102 Holiday Court  
Granbury, Texas 76048