Air Force Medical Service Structure

President’s Column

Col Timothy T. Jex, USAF, MC, CFS
Command Surgeon, HQ USAFE

As we finish celebrating the 50th anniversary of our Society, I am truly honored to serve as your new president. Thinking back on all the extraordinary people who have been involved with this society over the years, as well as the current membership, I feel very privileged just being a member.

Like most of you, I suspect, I hadn’t planned on making the Air Force a career when I was first commissioned. But it wasn’t too many days into my first assignment as a flight doc before I realized I had discovered the greatest job on earth. I still can’t believe I get paid to have this much fun. OK, technically there have been a few days that probably don’t qualify as “fun,” but still…it just doesn’t get any better. That said, we’re
FlightLines: Vision and Mission

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

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

Update Your Society Information!!!

Every few months, we fix common address errors, which may cause problems with mailing lists and prevent you from receiving your highly prized copy of Flightlines.

For USA addresses (including APO, Puerto Rico, Guam, and other US protectorates/territories), use your ZIP+four code.

To our overseas/foreign addressees: Update your address as follows:

Address 1: Street address as your country writes it.
Address 2: City/State/Postal code as in your country.
City: Enter your country’s name in ALL CAPS.

If you need more lines for your office address, move your country name to the zip code field (limited to ten characters). We may be able to add an Address 3 field in the future. In the meantime, we’ll continue fixing abbreviated countries. If you live in Ontario, your address should read like this on the website:

Address 1: 1234 Some St
Address 2: Orleans, ON K4Axxx
City: CANADA

If you have any problems, contact the Exec at Duncan. Hughes@brooks.af.mil or the webmaster at Robert.York@osan.af.mil for assistance logging onto the website or resetting your password.
This change in season has left me contemplating clichés and transitions. Let me start by paraphrasing the trite saying: “All endings are inevitable, but so are new beginnings.” The RAM 2011 class (Omega RAMs) has already taken over the excellent RAM X room in Bldg 775. This will be the last time this RAM classroom exchange occurs in San Antonio as Brooks City-Base closes and USAFSAM moves to Wright-Patterson AFB next year. And as pointed out by our new Executive Officer, Maj Ray “Doogie” Clydesdale, this FlightLines issue marks the culmination of SOUSAFFS’ 50th anniversary celebration. But the end of this event has also heralded the start of “new beginnings.” SOUSAFFS has named new officers and committee chairs; in addition, the FlightLines staff has also transitioned. However, the Society’s commitment to excellence and serving Team Aerospace (more specifically, our fellow Flight Surgeons) has not wavered. We will strive to make each 2010-2011 FlightLines issue educational, enlightening, germane and practical. Doogie has succinctly summarized our themes for this year in his column, “From the SoUSAFFS’ Executive Officer.”

This leads me to my next adage, “One must first walk before one learns to run.” Hence, we decided to go “back to the basics” for this issue. We geared our articles towards the new and/or junior base level flight doc who may not be familiar with the structure of and organizations within the USAF Air Force Medical Service (AFMS). We want to impart information that would explain some of the inner-workings of the AFMS and de-mystify some of those ubiquitous acronyms. Covering the complexities of the AFMS turned out to be an enormous endeavor and we hope to continue to include AFMS-related articles throughout the year.

“The only constant in life is change.” This adage rings true this time of year—commonly known as “PCS season.” The appellation Permanent Change in (Duty) Station may be the best example of an oxymoronic terminology we commonly use in the USAF. This change affects all of us at periodically during our careers. Many of you may have just survived this event yourselves. If this is the case, we hope you are settling into your new job and location and are ready to update your SoUSAFFS information. This will ensure that you will receive your next issue by mail and more importantly be able to become involved in your society.

We request that you let us know if you have ideas for improving our society, submit topics or articles, or just use us as a sounding board for any products or procedures that would benefit all flight surgeons. Please assist us and allow the Society to celebrate an exceptional year by participating and communicating your needs to us and by recruiting the newest generation of flight surgeons.

From the Exec

Maj Ray “Doogie” Clydesdale, USAF, MC, SFS
RAM X

The Society of USAF Flight Surgeon’s is finishing up its 50th anniversary. The 51st year will mark significant changes for the Society as we finalize plans for transition from Brooks City-Base in San Antonio to Wright Patterson AFB in Dayton. Our job is to provide as smooth a transition as possible so that members perceive the move as seamless.

In light of the transition, we’d like to apprise our readers of the remaining “themes” for the 2010-2011 year. By making our readers aware, we hope to get garner early feedback regarding the direction of the articles. Specifically, we would like our readers to participate in writing articles that they believe would be useful to other flight surgeons in the field. My favorite FlightLines issues were the ones I could use as a practical guide in our clinic or clearly and concisely explain mundane topics (like the disability evaluation system). We also want FlightLines to be a sounding board. Articles should be provocative by forcing us to look at classic flight medicine problems in new ways. We do not expect you to pull your punches. We encourage a “fangs out” approach.

Our next issue’s theme will be WAIVERS. Much of the issue will be dedicated to informing you of the issues surrounding the Aeromedical Consultation Service (ACS)’s move to Wright Patterson AFB. We would like our readers to tackle everyday confusing topics for new flight surgeons like: What is an aviation service code (ASC) and how do I (and why do I need to) accurately display this in the demographics section of AIMWTS? How does the Army disposition waivers in AERO and why I should care…. Is there an AERO advantage? Is AIMWTS broken? Why do we even bother with waivers... the Brits don’t bother with waivers…?

The winter issue will focus on medical enlisted personnel and what they bring to the fight. We’re looking for articles on Medical Enlisted Force Structure to inform the reader how our med techs develop from basic military trainees to 7 levels. For 4A’s, 4N’s, 4E’s, & 4B’s, how do they progress to each level, promote… what are their jobs/functions… how do we write effective EPRs for them? What are enlisted functional managers at the AFMS & Med Groups levels… who are they and why does it seem like they have more power than squadron commanders sometimes? What was a 4F and what is the “fix” coming to Flight Medicine? What are IDMTs… how do we mentor them… and why do they compete against each other for promotion rather than against the rest of the 4N crowd when they’re the best of the best? What is the role of the SME tech and are we adequately filling that role with quantity and quality? What is the medical enlisted force structure like for our sister services?

The final 2010-2011 FlightLines (spring) theme will focus on Flight Surgeon inspections. What & why are we required to inspect? What AFIs, policy letters, and memorandums guide us? How do we do a life support inspection for: fast-movers, heavies, rotary wing, and Army aviation assets? What’s the best way to do a Public Health sanitation visit? What are Category I, II, & III Ooc shops and how do we inspect them with the BEE’s? Why do we care about worker safety? What do you do if you find a problem… how do you assist shops willing to fix the problem and what tricks do you have up your sleeve to force compliance for unwilling shops? Who in the world has time to do all this?

Of course all articles are welcome regarding any and all topics outside of the themes presented above. We look forward to a great year where the Society will be responsive to the needs of its members in the field and aggressive in the recruitment of the next generation of flight docs.
The Medical Corps Chief is a position appointed by the AF SG and is usually an “additional duty” assigned to a MC General Officer. The MC Corps Chief works very closely with the Medical Corps Director, a MC O-6 assigned full time to AF/SG1, Medical Force Management. The MC Chief serves as the AFMS/AF physician representative internally to the Air Force and externally (joint, coalition, interagency, and civilian).

Internally, the MC Chief and Director focus on the force management of Air Force physicians. This covers a wide spectrum of subjects; recruitment (recruiting, scholarships, direct accessions), education and training (residencies, ACPE scholarships, PME), officer development (ADP, Development Teams), leadership development (SGH/SGP/Sq candidate recruitment/selection), and assignment assistance. In this role the MC Chief and Director interact with Air Staff, AFMOA, medical consultants, MAJCOMs, AF Recruiters, AFPC, the Cols Group, Wing/MDG leaders…just about anyone/any organization that impacts our corps. Additional responsibilities internal to the AF include policy development/review, medical consultation, program development/support (i.e., acupuncture), providing briefings/presentations, and just about anything “physician related” we are asked to assist with.

Externally, the MC Chief and Director engage our sister services as well as interagencies (Public Health Service, Homeland Security, etc) on physician matters (interservice transfers, joint training, physician specialty pays) and policy/guidance/information exchanges. The MC Chief serves as a delegate to the AMA and frequently interacts with international military and civilian physicians.

All in all, the MC Chief’s primary role is to serve as the senior AF physician providing force management oversight but the list of “other responsibilities” is just about anything else in service of the AF, the AFMS, and the AF/SG.

As noted above, the MC Chief position is not a primary duty so there is no formal “wire diagram” for the Chief (last year I was the Commander at Keesler Medical Center and now I am the ACC Command Surgeon). However, the MC Director (Col Dominic DeFrancis) is a primary duty and the position is assigned to HQ USAF/SG1 and works directly for the Assistant Surgeon General, Medical Force Development (Pentagon, Washington DC).

I know this has been a 30,000-ft view of the roles/responsibilities of the AFMS Medical Corps Chief. I would like to take a moment to discuss two specific topics; Development Teams and the AFMS Senior Leadership Conference. The Medical Corps Chief and Director meet approximately four times per year with senior MC officers and consultants at AFPC as our MC Developmental Team. These meetings last several days to a week and we essentially review every Medical Corps officer’s record (ADP, SURF, OPRs, etc) at least annually. We try to provide mentoring comments via the ADP so it is imperative that you keep these current and stay engaged with your leadership. The DT process is a significant mechanism/tool for you to use to vocalize your intentions/desires and to seek counseling/mentoring – take advantage of these opportunities. The AFMS Senior Leadership Conference is typically conducted at Leesburg, VA every October. This week long conference brings together all the AFMS General Officers, MAJCOM/SGs, MDG/CCs and Superintendants, AF Consultants, and a variety of key personnel from our Med Groups. This is another opportunity for you to engage…either via direct attendance (talk to your MDG/CC) or through other attendees (your MDG leadership, your MAJCOM/SG, or me). A theme and agenda are available before the conference so you can see what is going to be briefed/discussed and you can provide input/feed-back/comments to these discussions. This is also a great “networking” opportunity…either to take part in personally or to request advocacy from others attending. And if you are unable to attend, ensure those who do go from your MDG brief you/your Prostaff upon return.

Finally, I view my responsibility as the AFMS Medical Corps Chief is to be your/our advocate…I am available to talk to you about any/all issues. We can talk about what a good “next assignment” might be for you, or career aspirations, or education/training/deployment opportunities. I am very interested in your feedback (regardless of specialty) as well as your suggestions for improvement. Additionally, visit the AF Medical Corps homepage at https://kx.afms.mil/mc. This site has lots of great information; from career guidance and orientation, to education and training opportunities, to the latest info and a copy of the MC Newsletter…comments and suggestions for improvement are welcome (feedback button at the bottom of the screen or email me).

The mission of the USAF is to Fly, Fight and Win and AF Medicine supports that mission with Trusted Care Anywhere. Each and every Medical Corps officer must be prepared to engage as Wingmen, Leaders, and Warriors! Please feel free to contact me with questions, comments, and suggestions.
From the ANG

From the Air Surgeon

Col Brett “Doogie” Wyrick
NGB/SG

“Go in Big or Go Home... now is not the time for the faint of heart—
for we need strong souls of character and fortitude, and I intend to
send you into Harm’s Way.” Fellow Guardsmen, there is a reason why
we wear the United States Air Force uniform—because in
time of need, we exist
to serve our nation as
well as our state. Each
and every one of you
holds a commission from
your sovereign state, and
you also hold a com-mis-
sion as a Reserve Officer in
the United States Air Force.
(Go back and read the fine
print on the certificate if you
have trouble believing this
fact.) We organize, train, and
equip according to the method
prescribed by
Congress, and
that method
belongs to the
USAF. The
nation has
a need for
us in this
time of
war, and
the greatest
need pre-
ently exists in
the realm of
Critical Care Air
Transport Teams
(CCATT). Ten years
of continuous warfare
have worn the CCATT
community thin, and it is time
we took up some of the slack. To this
end, we are trading some of our unused surgical
capability out of our EMEDS and converting it those
unfilled Unit Type Codes to CCATT.

This decision is not made lightly, but it is based on several facts that are
evident from our history. In the first place, we have never been asked to
go do surgery in any contingency operation...yet. We have been asked
to move critically ill patients, and we continue to get this request every
year during the hurricane season. We need to tailor the UTC’s for the
missions that are out there, and we need to be responsive to the needs
of the USAF in an agile and nimble fashion. In the ANG, we have a
wealth of experience taking care of the critically injured in our day to
day civilian practices. We also have a number of people who have done
the CCATT mission in the past and mourn the loss of the UTC. We are
looking to send our first teams out the door in the early part
of next year. If you want to
be a part of this, please
contact me at the
ANG Readiness
Center. We are
signing up for a two
year commitment to
participate in the war. I
need all the heavy hitters
on deck

Recently during one of the
recent crises, I had several
ANG physicians ask me if
they could volunteer and
go in a civilian status. The
answer is yes,
but do you
really want
to do that?
All of
us are
volun-
teers,
and
we
have the
mindset of
“marching
to the guns”. How-
ever,
there is a
reason why
things work the
way they work in the
military, and the simple fact
is that however bad the present
crisis may be, we are a nation with global
responsibilities, and the next crisis or disaster
may be bigger than the present emergency. When they
call the Guard, they need the Guard. That is when we need
you to be ready to go, and it is difficult to reach out and touch you
if you are at the disaster in a civilian status. Keep your powder dry, and
train your folks to be prepared. Keep us informed of your readiness, and
do not give in to “Rescue Fever.” Unfortunately, the way the world is
running, the next crisis or disaster is not far off, and I can guarantee with
a high degree of certainty, the time is coming when we will need you
in a military role. Prepare yourselves, train your people, and make your
families- and yourself, ready and resilient. 

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The Combatant Command SG: The Basics (An Interview with Col David Schall)

Maj Geoffrey “Rock” Ewing, USAF, MC, FS
Omega RAM

Recently, the Omega RAMs (RAM-2011) had the opportunity to hear from Col (Ret) David Schall. Additionally, Maj (Dr.) Geoffrey “Rock” Ewing had the chance to discuss COCOM SG structure and function with Col Schall. I echo Rock’s sentiments of appreciation for Col Schall’s candor and time. His words were truly enlightening and will educate many of our Flight Surgeon brethren. The following is a summary of their question and answer session—(Sr. Ed.):

Thanks for your lecture day of clinical insights from your specialty and your leadership pearls. I’m sure they were hard earned and I particularly appreciate them.

This issue of FlightLines will focus on the AFMS for the flight surgeon. As former EUCOM SG, we would greatly appreciate your insights on the AFMS at the COCOM level to better inform the flight surgeons from the basic AMP GMO FS on up.

We would appreciate you insight into the questions below and any other information you think would benefit this audience.

1.) What is the mission/role of the COCOM SGs in the AFMS and its own organization structure?

The Combatant Command Surgeon is the senior medical advisor to the Combatant Commander. As such they are not in the AFMS chain. They are at the Joint level. They do work with the Service SG’s but are not under their authority. This sometimes causes confusion, since a service SG will send out a policy that may be in conflict with a COCOM Theater policy. Doctrinally, the COCOM SG determines the requirements, then the service SG trains and equips to meet those needs. Normally the COCOM SG oversees all Theater Health Service Support, to include Joint and Combined Medical Plans, Operations and Theater Security Cooperation. The COCOM SG also directs deployment of Theater Medical assets, Theater Aeromedical Evacuation and Blood Distribution systems. For EUCOM, the SG also coordinates with NATO, Joint Staff, other unified commands, as well as the 4 service components. He is also charged with overseeing the welfare of the military members and their families that are assigned to that Theater.

The COCOM SG staff is usually much smaller than the Component SG staffs and is obviously filled by representatives from all the services. Typically they will have an MSC planner from each of the services, a medical logistician, a Public Health/Force Health Protection officer, a CBRNE officer, a Blood officer, an AE officer, and an IHS officer. However, this varies from COCOM to COCOM and some positions are filled by activated reservists depending on the mission requirements.

2.) Where are the COCOM SGs in the Org Structure?

The COCOM Surgeon normally reports directly to the Combatant Commander, however for day-to-day operations this may be delegated to the DCOM (Deputy Commander) or to the CoS (Chief of Staff). EUCOM, Joint Staff SG and the NATO SG were under the J4 (Logistics) but have since been reorganized to report to the COCOM Commander. The debate of the proper location of the SG has been ongoing since WWII. Unfortunately the Joint Pubs do not address this except in deployed situations. This is something both the JS-SG office and JFCOM on working to rectify. Presently medical is in all the J4 series pubs.

3.) Are there any uniquely important responsibilities the COCOM SG has?

The COCOM SG is responsible for getting all the medical components to work together to achieve the Theater Commanders objectives. This can be a challenge because the Component SG’s have many “masters” to serve.

4.) What are the authorities of the COCOM SG?

The authorities for the COCOM SG are derived from the authorities given to the Combatant Commander he or she serves. They are also directed by the Joint Pubs, Directives from the SECDEF or CJCS, the President and Congress.

5.) In the COCOM SGs’ relationships with other services and countries what authorities, roles, or responsibilities would it be important for the flight surgeon to understand?

Doctrinally, the COCOM SG is above the theater service component SGs. This may be confusing at times when there is rank inversion with one of the components as in EUCOM (the USAEUR SG is a Brigadier General while the EUCOM SG is an O-6). With other countries, it can be complex, since in EUCOM, NATO is the main networking organization and the Senior US Medical representative is the JS-SG. However, since the EUCOM SG works with those countries on a day to day basis, they also interface and help to coordinate on deployments, exercises and policies.

6.) How are policies/directives and AFIs routed through or created by the COCOM SG and integrated/implemented?

At the COCOM level we do not see service regulations. We review proposed DoDIs and changes or updates to them; additionally, we send them to the Component Surgeons for chop and/or comment.

7.) Are there any misperceptions, misunderstandings, or unappreciated capabilities or limitations the COCOM SG?

Common misconceptions: The COCOM SG office has lots of money- FALSE. While we may have the ability to direct funding from other sources down to the Component, most of the time it comes from the Theater Component baseline.
The COCOM SG has a large staff and can do everything a Theater Component SG staff can do—FALSE. Being a joint assignment, the HQ relies on the Services to fill the required billets. Often the Services will allow these to go vacant, which can handicap the COCOM SG ability to respond. The COCOM SG may direct or task a Component SG to perform a HQ function, for example USAFE handles the day to day oversight of Theater AE for EUCOM. USAEUR through Landstuhl manages the Theater Blood assets on a day to day basis.

The COCOM SG is getting a copy of all your latest AFI’s and Policy letters—FALSE. We do not get to see your latest pubs and rely on the Component Surgeons to inform us of significant change.

The COCOM SG directs MILCON and Medical Staffing for the Theater—FALSE. While it is true that the SG can influence that by the requirements that are written, the COCOM SG normally does not perform that function and allows the Services to determine specifically what is needed to meet that Theater’s requirement.

8.) Do you have any other insight from the COCOM SG’s perspective that would be valuable to the basic FS?

Many Flight Surgeons grow up in a pretty homogenous environment with little joint experience with other services or other countries except for the occasional exercise. Further, they tend to see only through AF lenses, often failing to grasp the “Big Picture.” We do not operate in a vacuum; we are part of a bigger picture in accomplishing the Commander’s intent. To be able to serve effectively at the COCOM levels it is important that you understand the language and needs of the other services. The best way to get that is through a tour with a sister service or an assignment at a Joint HQ. Furthermore, it is important to have served as a Component Surgeon before moving into a COCOM SG position. Coming to this job as an MTF Commander does not equip you adequately to do that job. By the time you figure it out, it’s time to PCS. Understanding how to work effectively with Senior Flag officers and Ambassadors is a skill that is not developed overnight. It becomes even more challenging in the Joint environment. Additionally, having an appreciation of what other offices in our government (like DoS-Department of State) as well as other countries have to offer is essential in working in the International environment. These kinds of experiences do not normally happen in a typical flight surgeon career path and must be sought after. It requires stepping out of your comfort zone. Go for it! ✌️
As a flight surgeon and member of Team Aerospace, your missions and responsibilities are much broader than simply providing medicine and healthcare to your patients. You are one of the primary interfaces between Air Force medicine and our brothers in arms within the line of the Air Force (LAF). Specifically, you and your aerospace medicine colleagues, the bioenvironmental engineers, public health officers, nurses, and aerospace physiologists, work directly day in and day out with the rest of the wing and other organizations at your base or airborne in air operations. It is therefore important that you have a working knowledge of what the medical group (MDG) is and its general role and missions within the Air and Joint Forces. This article is intended to provide you with a quick overview of the Medical Group and where the flight surgeon (FS) fits in. Must reading for all FSs is the “Air Force Medical Service Flight Path”, which is found at https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=FlightPath.

I interviewed Colonel Don “Grinder” Hickman and Lt Col Charlie “Chuckles” Clinton, respectively the 75 MDG/CC and 75 AMDS/CC at Hill AFB to help define the AF Medical Group and the FS’s role in that organization. They offered some tremendous insights, perspectives and advice to FSs.

In garrison (at the non-expeditionary Air Force Base), Air Force medical treatment facilities (MTF) are categorized as medical wings, medical centers, clinics with squadrons, and limited-scope medical treatment facilities (LSMTF). Most commonly these MTFs are commanded and controlled within the Air Force as medical groups (versus medical wings or medical squadrons). Generally, this places the MDG on par with the other groups (usually the operations, maintenance, mission support groups) in the typical wing at the typical base.

The Air Force Medical Service is unique among the three military medical services. We alone work directly for our wing commander. As medics, we answer directly to the LAF chain of command, not through a medical chain of command as in the Army and Navy. The typical wing organizational structure is described in Figure 1.

Figure 1: Typical Air Force Wing and Medical Group Structure
The typical MDG has four squadrons and is commanded by a medical colonel from one of the five AFMS corps—the Medical Corps, Dental Corps, Biomedical Science Corps, Nurse Corps and Medical Service Corps. The typical MDG is structured with a medical support squadron (MDSS), medical operations squadron (MDSO), aerospace medicine squadron (AMDS) and a dental squadron (DS). With few exceptions, new FSs are assigned to the aerospace medicine squadron or to squadron medical elements (SME) in an operational (LAF) squadron and operate in the AMDS.

The MDG commander has the overall responsibility for all activities of the MDG and is accountable for accomplishment of all aspects of the MDG mission. The commander serves as the chief executive officer, the local representative of the governing body and the medical advisor to the wing/installation commander.

Col Hickman noted the critical continued importance FSs to our Air Force, and the important functions and service they provide to a wing’s missions. “First off, it is critical that new FSs ensure that they are squared away officers and physicians. I put officership first – the FS, with your Aerospace Medicine colleagues – are very public faces to the LAF representing the MDG and all the men and women of the MDG, including the commander. Second, your clinical skills must be second to none. The customer expects nothing less and any screw up clearly effects operational readiness of the unit you’re supporting. Third – as a new FS, you will be honing the skills you learned in AMP. You will be working many programs that at first may seem bureaucratic, mundane and not what you signed up for. Think again – your customers are not just your patients. Your customers are the commanders and shirts who rely on you to do the right thing in the DAWG, OEHWG and with MEBs, and with PRP, and in SIBs and AIBs, and as the PHEO, and in…well, you should get the point. You have a direct responsibility for providing the highest quality products and advice that directly support the operational missions of the Air Force, and the Joint Force.”

Lt Col Clinton describes, “The flight surgeon is a critical spear in the fight. The unique skills, knowledge and experience of the FS can bridge the missions of the LAF and the MDG which can often be foreign worlds to each other. The FS can have important influence between the two and is in the unique position to see obstacles to the mission and their solutions others cannot. We should be the positive representative of one to the other, communicate critical information, and provide the clarifying grease of mission situational awareness to each thus eliminating costly and painful misunderstandings.”

On the relationship between the FS and the MDG/CC and other senior MDG leadership, Col Hickman offered this advice. “The new FS mustEarly on establish a relationship with the MDG leadership. It doesn’t matter if you are assigned as a FS in the MDG or an SME, you are one of the MDG commander’s representatives to the LAF. Your SGP and/or AMDS commander is the lead interface between you and the MDG/CC. You must understand what the MDG/CC needs from you. You have a responsibility to ensure that aerospace medicine issues requiring the commander’s attention are in fact presented to the commander.

Col Hickman stated, “MDG/CCs come from all corners of the AFMS – some are experienced in aerospace medicine, some are relatively inexperienced. I tell all my officers that they must not assume that I am current in their issues and that have the responsibility to make sure I ‘get it’. Do not take this to mean ‘cleared hot to bombard the O-6 with emails.’ It means do your due diligence and staff work, work with your SGP to understand what the ‘Boss’ knows/doesn’t know, how best to

brief him, how best to communicate with him, etc. Like I said earlier, you are working programs that are very high-visibility to the LAF. Make sure the MDG/CC knows what’s going right, and darn well make sure the MDG/CC doesn’t get broadsided because you failed to follow up…bad news never gets better with age.”

Col Hickman also gave some valuable insight into how to work in an organization that has requirements that exceed resources. “I imagine most of you think you’ve worked in resource constrained environments in the past. Well, to the new FS, you haven’t seen anything yet. The Air Force is producing new FSs as fast as it can, yet for the short and near term you will most likely be assigned to clinics that are chronically short of FS manpower. The ‘Long War’ will continue; FSs – along with the rest of Aerospace Medicine – will remain one of the primary deploying forces. You will experience long, lonely days sometimes…and you must always perform at 100%.” Lt Col Clinton adds, “Often, in addition to juggling priorities, the FS has to deal with competing requirements based upon what the wing or line want us to do and what medical AFIs direct us to do.” In the end, these conflicts eventually get resolved and the mission completed.

Col Hickman continued, “I’ll pass on something a former wing vice commander once told me and all my fellow squadron commanders. The Wing had just tanked its third Operational Readiness Exercise in a row, and he was ‘mentoring’ about how to juggle competing priorities with not enough resources to do everything the multiple AFIs directed the ABW to do (remember – the AFIs all say ‘Compliance with this Publication is Mandatory’). He said: ‘It’s your job to know which tasks you’re juggling are bowling balls and which are tennis balls. You cannot drop the bowling balls…they don’t bounce back. You shouldn’t drop the tennis balls…but, if you must, you know they will bounce back.’ FSs juggle many competing priorities that are all very important to the MDG Commander and LAF Commanders across the base.”

Knowing the significance of these priorities or being able to judge which are bowling balls and which are tennis balls relies on FSs being clued in and communicating with leaders. Practically, this means attention to meetings, minutes and emails—it means understanding team aerospace programs and then letting your leaders know how you are balancing your time and efforts. Col Hickman emphasized, “Practice good operational risk management, communicate well and often with your SGP, AMDS/CC, MDG/CC and LAF leaders, and make it a priority to get your flying in (it is the expectation and fringe benefit).”

As you understand how you fit into the MDG and maintain these professional and clinical standards you will establish an important credibility and influence that will make your work as a flight surgeon meaningful and rewarding.

Col Hickman has 23+ years in the Air Force as a bioenvironmental engineer, commanded an AMDS and has commanded the 75 MDG for 14 months.

Lt Col Clinton has served the Air Force for 17+ years as a medic and 8+ years experience as a Flight Surgeon and RAM and is now three months into his second AMDS command tour in the 75 MDG.

Maj Geoffrey “Rock” Ewing has served as an AF medic for 10 years, 5 of which have been as a flight surgeon. He is currently in the USAFSAM, Omega RAM 11 class.
In May 2003, the U.S. Air Force Surgeon General called upon the Society of U.S. Air Force Flight Surgeons to report on the state of the flight surgeon from a perspective external to the traditional chain of command. This survey is the third inquiry aimed at garnering the opinion of medical treatment facility (MTF) commanders on the quality of today’s flight surgeons, the level of training of new flight surgeons, and the level of preparation of aerospace medicine specialists who graduate from the Residency in Aerospace Medicine.

MTF commanders were surveyed using a commercial web-based survey tool with a 76% response rate. Data were compared against the previous two surveys (completed in 2005 and 2007) to determine if differences were present across the survey series.

In terms of overall satisfaction with base-level flight surgeons (FSs), the majority of commanders are satisfied (69.4%); however, comparison to the previous two studies shows a decrease in the percent with a favorable rating (although not statistically significant). Careful analysis of the dissatisfied responses reveals that the quality of physicians is quite good, but the inexperience of newer FSs combined with inadequate mentorship and decreased manning accounted for 68.4% of the negative responses. When compared to the 2007 survey, Medical Group commanders (MDG/CCs) view oversight as significantly improved in public health, bioenvironmental engineering, and optometry programs. This year’s survey also showed an improved opinion of oversight in health promotions, occupational medicine, and flight medicine programs, but this was not statistically significant. Overwhelmingly, MDG/CCs prefer a lieutenant colonel in the role of Chief of Aerospace Medicine (SGP) (77.4%) and feel that the Aerospace Medicine Squadron commander (AMDS/CC) position should be filled by a lieutenant colonel (83.9%) as well. These data were not substantially different from the two previous studies. The most desired area for improvement of flight surgeons was in leadership/mentorship at 65.6% (40/61) of responses. The second most desired improvement, 41% (25/61), was in the level of MTF cooperation/participation.

It does appear that commanders are more concerned with the level of training out of the Aerospace Medicine Primary (AMP) Course, with a positive response being gathered only 47.5% (29/61) of the time as compared to 76% in 2005 and 81.6% in 2007. These data are tempered by the comments given by the 32.8% (20/61) of commanders who responded negatively. Of these 20 negative responses, 60% (12/20) reported that the AMP is actually a good start, but that serving as a flight surgeon requires mentoring or “growing” of the AMP graduates for at least the first 6 months to 1 year. Additionally, 20% (4/20) of the negative responses also said that the AMP is a good start, but that an individual’s lack of experience in the Air Force or in clinic places him/her behind other physicians. Only 10% (2/20) of negative responses were directly related to dissatisfaction with the AMP Course itself. When asked about the newest AMP graduates, MDG/CCs seemed relatively satisfied, with approval percentages of 3.3% “excellent,” 45.9% “good,” and 44.3% “adequate.” Only 6.5% of MDG/CCs reported overall performance of new graduates as being marginal or poor. The top subject commanders wanted emphasized in the AMP Course was aerospace medicine programs, with 44.3% (27/61) response. The second most prevalent emphasis item was medical standards at 39.3% (24/61). Other well-represented subject emphasis items (in descending order) were the Personal Reliability Program (PRP) at 24.6%, officeranship/leadership (23%), and clinical aviation medicine (16.4%).

The overwhelming desired focus of the Residency in Aerospace Medicine (RAM) for future job training was for the SGP role at 88.3% of MDG/CCs. Squadron/CC was the second most prevalent choice at 51.7%. This compares quite closely with the 2005 emphasis and diminishes the emphasis on Flight/CC preparation, which was a more frequent response in 2007. Commanders agree that the RAM is preparing the residents for SGP responsibilities. However, they also agree that the RAM is not preparing RAM graduates to assume the Sq/CC role. In the 2010 survey, of the 60% that responded negatively to preparation for Sq/CC, the majority (63.9%) reported that they did not see the connection between the residency and Sq/CC or they did not have the expectation that a residency would prepare a flight surgeon for the responsibilities of squadron command; however, 19.4% (7/36) of these same negative responders had fundamental concerns with the lack of leadership/officer-ship displayed by the RAM graduates with whom they had contact. The top subject commanders wanted emphasized in the RAM was clinical aviation medicine at 38.3% (25/61) of responses. The second most prevalent emphasis item was a tie between the Master of Public Health degree (or equivalent), leadership seminars, and occupational medicine at 28.3% (17/61) each. The 2007 RAM subject emphasis priorities were leadership and aerospace medicine program management. The 2005 most cited items were leadership and occupational medicine.

This survey provides a snapshot of the current opinion of MDG/CCs on the quality of flight surgeons in the USAF as well as the level of preparation of flight surgeons in AF training programs. Caution should be used in making large-scale curriculum changes based on the results of one study, as it is only sampling one of the three main stakeholders (the others being flight surgeons and the line units that the flight surgeons support). Per USAF Surgeon General’s direction, future “State of the Flight Surgeon” surveys will be a consolidation of all three stakeholders and presented once every SG cycle. This new format of the survey may give a more complete picture of the State of the Flight Surgeon.

Overall, MTF commanders appear to approve of flight surgeon oversight of aerospace medicine programs, the Aerospace Medicine Primary Course, and the Residency in Aerospace Medicine training program. Negative opinions about the level of training or satisfaction with flight surgeons in general were overwhelmingly due to lack of experience, inadequate manning, and/or lack of base-level mentorship. These results may indicate a frustration with the level of manning and an inability to resource time to provide necessary “on-the-job” training in the first years out of the AMP. ✶
A couple weeks ago, the Afghan National Army (ANA) Medical Command graduated its first class of medical logisticians. To mark that monumental day, Mike Brown, the course director, said, “It is a great day to be a Soldier.” Two days ago, it was the ANA Air Corps’ (AN AAC) turn to have a great day when they graduated their first class of Flight Surgeons. The significance of this AN AAC event was recognized by the distinguished visitors who marked the event, including LTG Darwan (ANAAC Commander), MG Yaftali (ANA Surgeon General), MG Azimi (MOD Spokesman and MoD Deputy for Parliamentary Affairs), BG Barat (Kabul Wing Commander), and Brig Gen Boera (Combined Air Power Transition Force and 438th Air Expeditionary Wing Commander). As a USAF Flight Surgeon, that event was my turn to say proudly “It is a great day to be an Airman.”

This Flight Surgeon graduation was the culmination of months of effort by COL Rasoul (ANAAC Surgeon), Col Diane Ritter (previous ANAAC Surgeon Advisor), Lt Col Jeanine Czech (course director), and many other Afghan Airmen and advisors. During their nine month course, the six newly-winged Flight Surgeons learned the evidence-based principles of aerospace physiology, spatial disorientation, flight safety, and physical standards. With their newfound knowledge, these six Airmen form the nucleus of future ANAAC Aerospace Medicine cadre. The result is that, for the first time, the ANA has doctors with knowledge and skill required to advocate for the health and welfare of the flying mission.

Aerospace Medicine is not just primary care medicine for aircrew and their families. Aerospace Medicine is all about prevention and health promotion that improve flying safety and mission accomplishment. Flight surgeons are required to participate actively in their unit’s flying mission in order to gain first-hand appreciation for the human challenges of aviation. Flying as crew members also helps flight surgeons gain the trust and confidence of their patients. It is said that the flight surgeon is the only doctor who routinely puts his life in the hands of his patients. With the expertise these new flight surgeons have received, they and the mission will be in even better hands.

But their training is not over yet. Like any great medical education program director, Lt Col Czech, proud Mom that she is, is already planning the next phase of their Aerospace Medicine training: These six flight surgeons will remain in Kabul a while longer to continue their training and gain experience. Their growing expertise will allow them to become teachers themselves: teachers of other flight surgeons, teachers of other Airmen, teachers of other fishermen. THAT is building enduring capacity in the Afghan healthcare system. It was and is a great day to be an Airman. ♠️
The New Integrated Disability Evaluation System (IDES)

Maj Ray “Doogie” Clydesdale, USAF, MC, SFS
RAM X

A couple of years ago the Army went through the Walter Reed “mold-on-the-walls” scandal. Quite a few folks lost their jobs. The WRAMC Commanding General was fired, the Secretary of the Army resigned, and the Surgeon General of the Army was forced to resign. The wake of the scandal brought former U.S. Senator Bob Dole and former Health & Human Services Secretary Donna Shalala together at the behest of President George W. Bush to lead the President’s Commission on Care for America’s Returning Wounded Warriors (nicknamed the Dole-Shalala report). One of their six recommendations will directly affect you in flight medicine, especially if you are an active participant in the DAWG (Deployment Availability Working Group).

The recommendation was to significantly restructure the disability and compensation systems. What was confusing for most service-members undergoing medical separation from their service was the disparity between the disability ratings determined by their DoD service branch and the VA’s disability ratings. The commission determined that the disparity between services was concerning. The Army, especially, was accused of low-balling disability ratings.

Individual Airmen can incur a wound, injury, or illness (whether serving in combat operations or at home station) that may have a long-term impact on their lives and ability to perform their duties as an Airman. With the aid of exceptional medical care and adequate time to heal, most Airmen recover and return to full and unrestricted duty. Unfortunately, some Airmen do not fully recover. In this case, it is appropriate for them to be referred to the Disability Evaluation System (DES) process that will determine their fitness for continued military service. DoD and the VA are developing and implementing an integrated DES (IDES) to streamline the overall DES process. The most significant change is that the Airman will have his VA disability evaluation done while he is still on active duty, avoiding the gap that currently occurs when an Airman separates, receives his VA evaluation, and finally becomes entitled to VA benefits (up to a year after he separates from the AF). The IDES is currently operational at six Air Force bases as a pilot program (Andrews, Travis, Vance, Nellis, MacDill, & Elmendorf). IDES is tentatively scheduled to be deployed operationally across the Air Force in 2011, although its planned rollout has already been delayed.

When considering a patient’s medical condition, a primary care manager (PCM) must render an assessment for duty fitness. Duty-limiting conditions are annotated on the AF 469 and profiles on the AF 422. A patient’s condition may render the individual incapable of performing military duties, deploying, or functioning in his/her career field (AFSC). At some point, the condition may be serious or chronic enough to warrant discharge from the Air Force (IAW AFI 48-123). Ideally, the DAWG would already be tracking this individual so a Medical Evaluation Board (MEB) recommendation from the PCM would not surprise anyone. One of the new tricks up the Air Force’s sleeve is called the “Fast-Track MEB.” Despite its name, it is not officially an MEB (therefore a code 37 should not be initiated, or as stated in AFI 10-203 3.4.5.2. that a code 37 should be changed back to a code 31). It’s a review-in-lieu-of an MEB format (RILO-MEB) that is forwarded by the DAWG to AFPC/DPAMM if it appears that the patient has a high likelihood of returning to duty (unrestricted or C-coded). DPAMM (part of the Assignments Directorate at AFPC) will render a decision back to the DAWG to return the member to duty, either unrestricted or C-coded, or DPAMM will recommend finalizing and forwarding an MEB to AFPC/DPDSD (part of the Personnel Directorate at AFPC) which is where the Physical Evaluation Board (PEB) convenes.

The Informal PEB (IPEB) receives the forwarded MEB package from the Med Group’s Physical Evaluation Board Liaison Officer (PEBLO). The MEB package included the Narrative Summary (NARSUM), Single Unit Retrieval Format (SURF), AF 618 Medical Board Report, Member’s Letter of Exception (optional), Commander’s Letter, AF 469 (+/- AF 422), pertinent consultations, and the entrance physical exam. The MEB package is reviewed to determine fitness for duty, determine Line of Duty (LoD), determine combat-related conditions, and determine disability ratings (caused by the defects that led to a shortened military career). The key factors determining fitness for duty include current duty performance, deployability, medical risk (to include risk to the system), military standards, AFSC duties, among others. Each case is obviously individualized based on all of the information provided. The IPEB can return a member to duty (unrestricted or C-coded via DPAMM), discharge the member as unfit, or temporarily retire the member to see if the condition improves with time.

The disability ratings are determined by law. The IPEB uses the Department of Veterans Affairs Schedule for Rating Disabilities Index (VASRD... pronounced “vass-erd”). Most of the disability ratings are based on medical standards from 4, 5, and 6 decades ago. Although modern medicine has changed outcomes for many disease processes, the ratings for many conditions remain antiquated. Unfortunately, many of these ratings are solidified in case-law. When an airman is discharged from the Air Force for an unfitting condition, the airman is awarded a disability rating for that unfitting condition(s) [and only that unfitting condition(s)].

The disability rating can range anywhere from zero to 100%. A disability...
rating of 30% or more garners the service-member retirement to include an ID card and a monthly check equal to the percentage of their base income for the rest of their life. 50% disability gets you 50% of your base pay, 100% gets you 100% of your base pay. Disability ratings of 0%, 10%, or 20% all mean the same thing; the airman will get a one-time severance payment of 2 x Years in Service x Monthly Base Pay. There is a catch called “Concurrent Receipts”. Although this airman receives compensation from both the Air Force and VA, the airman does not get to keep both. The airman will only get VA’s monthly compensation as the Air Force disability compensation will be offset by the VA’s compensation. Therefore the airman cannot double-dip. This applies to both the severance package and the monthly disability payment. Disability ratings are always rounded to the nearest 10th percentile.

This is where the new IDES comes in. The airman found unfit by the IPEB must now go to the VA for a physical exam where the VA’s disability rating will be determined. The VA rates everything service-related, while the military services rate only those conditions which affect the member’s fitness for duty. The specific rating that the VA gives for each of the unfitting condition(s) must now be incorporated by the IPEB. The IPEB used to do this by themselves, and this is where a perception developed that the DoD was low-balling service-members. You can see how this new process has the potential to slow the system way down.

One of the key sub-recommendations of the commission was to keep the service-member informed about the entire process. The service-member can appeal or challenge during the MEB. If the member is not satisfied with the recommendation of the IPEB, then they can appeal to the Formal PEB (FPEB). The Airman travels TDY to Lackland AFB where they typically meet with counsel and plead their case to the FPEB (to stay-in, get-out, or get a higher disability rating... say 30%). If not satisfied with the FPEB’s recommendation, they can appeal to the Secretary of the Air Force Personnel Center (SAF PC). Whenever the final verdict is rendered, it is now recommended now the PCM sit down and explain the findings of the PEB to the service-member. The PEB issues an AF 356, the Finding and Recommended Disposition of USAF Physical Disability Evaluation; Box 9A Diagnosis, Box 12 Recommended Disposition, and Box 15 Remarks are the key findings by the PEB that should be reviewed by the DAWG and then by the PCM with the service-member.


The SGH and SGP should be familiar with the VASRD. When forwarding an MEB to the PEB, it will be helpful to look up the diagnosis in the VASRD, not to figure out the potential disability rating, but to determine if the appropriate exam was completed so that it doesn’t have to get sent back down from the PEB for more information. One of the more common mistakes is to send a NARSUM up to the PEB for a musculoskeletal condition that does not include range of motion for the affected joint(s). The range of motion exam method is also critically important. The DAWG may want to enlist the physical therapist at the base to perform these range of motion exams (using a goniometer per the VASRD) for all musculoskeletal condition MEB’s. The key is to perform the exam correctly the first time using the VASRD as a guide. For the current VASRD, visit www.warms.vba.va.gov/bookc.html.

There is, of course, a litany of individual circumstances that can make any disability adjudication process prolonged. The folks at DPAMM or at the IPEB want you to know that you can call or email them with any question you have so that you can better understand the process and help things go more smoothly at your local base. This article only scratches the surface of the DES process, but hopefully can orient you to current and future disability operations. ▲

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MTM-Field is a two-week mentored experience in a foreign partner nation in two settings—academic referral centers and remote sites. Both clinical and public health aspects of practicing medicine in these settings are explored. Mission sites, dates, and activities vary annually; this year’s MTM-Didactics graduates travelled to Peru, Ghana, Honduras and Kenya.

MTM didactics is a pre-requisite for the field course can be taken together or the field course may be taken up to four years later. For MTM-Field, physicians who are applying for MTM-Didactics in the same fiscal year or who have successfully completed MTM-Didactics within the previous four years may apply. Physicians may submit an application at any time; however, these are only valid for the fiscal year in which they are submitted. Applicants must include in their requests the months in the same fiscal year during which their command supports a two-week assignment.

Normally an elective of the Residency in Aerospace Medicine, Military Tropical Medicine is open to any physician who supports deployment medicine and is centrally funded. The application form for this course may be found at: http://www.med.navy.mil/sites/navmedmpte/courses/Pages/OperationalCourseNominationForm.aspx. Further course information is located on the web at: http://www.med.navy.mil/sites/navmedmpte/courses/Pages/MilitaryTropicalMedicineCourse.aspx

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