President’s Column

Hernando J. Ortega, Jr., Col, USAF, MC, CFS
President, Society of United States Air Force Flight Surgeons

Why Do Flight Surgeons Fly?

Greetings again, flight docs. Welcome to the Fall 15 edition that will attempt to answer that question. Your officers have been working hard to transition the organization leadership and establish our “battle rhythm” for the coming year. Hopefully you’ll see some results in this edition and like what you see.

As you’ll recall, I challenged each of you to 1) advance Aerospace Medicine (AsM), 2) recruit and retain more flight surgeons and AsM specialists, and 3) foster continuing professional development and leadership. I also said that #3 was the big one, so to speak.

I did some research into the archives on how those before us dealt with some of these issues. I can’t say it much better than Col Touhey did in his first president’s column (see page 2). My target is the same as his—an informative and stimulating newsletter. To those ends, we’ve excerpted some classic treatises, dug up some “best of FlightLines” articles that every flight doc ought to know, commissioned some specific, topical articles, and reprinted vital subjects so that you all will be equipped to do all of the three things above. Every edition of FlightLines is a good read. But if I say so myself, this is an awesome edition!!

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Around the Air Force

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The views expressed in this newsletter are those of the authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
So why do flight surgeons fly? This question is at the core of why there are flight surgeons and how we do our critical function in delivering airpower for the nation’s defense. We start with our consultant’s recap of the last State of the Flight Surgeon survey results. The Hap Arnold piece describes for you the operator perspective on what a flight doc ought to be—classic and still right on target per Mobbbc’s article. Then we have the preface of what I consider THE seminal paper on what it means to be an Air Force flight doc, commissioned by Lt Gen (ret) Peach Taylor and authored by preeminent USAF flight docs David Jones and Roy Marsh. I strongly recommend you google the title or this document number (SAM-FE-BR-TR-2003-0001) for the full and rich historical details of your current profession. Next I asked the Iguana, Dr. Hadley Reed, to reprint his classic AMP lecture on the question. And I actually got him to reprise his article with over a decade’s additional perspective. You learn why flight surgeons are special to the combat operations of the USAF, the importance of your wings, what they mean to air warriors, and your responsibility to keep faith. Trust, character, and integrity are the keystones of doing the job. Since the AFMS is in the process of rebuilding the 4N0X1-F career field, we’ve pulled together some history of what the traditional flight medicine support enlisted career field was like. There is a 1998 FlightLines tribute by Dr. David Jones to the 901s, which changed to 4FOX a couple of decades ago. There is also a historical perspective from Mr. Mike Landez, current deputy chief of medical standards at AETC and a former 901/4FOX. Please share these with your technician staff as we flight docs help orchestrate the vital resurgence of medicine support enlisted career field. There is a 1998 FlightLines tribute by Dr. David Jones to the 901s, which changed to 4FOX a couple of decades ago. There is also a historical perspective from Mr. Mike Landez, current deputy chief of medical standards at AETC and a former 901/4FOX. Please share these with your technician staff as we flight docs help orchestrate the vital resurgence of medicine support enlisted career field.  

This is one of those “cover to cover” editions that is chock full of valuable information and perspective on the “greatest job in the Air Force!” IMHO, this edition will be a must-read for several years to come. I would ask each of you who read these words to pass the entire newsletter on to at least two other docs (flight doc or not) and to your commander. Post it on Facebook, Tweet it out, Link it in, or just plain email it! I’m pretty sure it will be useful in 1) advancing AsM, 2) recruiting and retaining more flight surgeons and AsM specialists, and 3) fostering continuing professional development and leadership. Thanks again for the opportunity to lead this great organization and keep ‘em flying! ♦

Bugs
Hernando J. Ortega, Jr., MD, MPH

New Aeromedical Standards App Available

Med Standards, an app that presents the medical standards for special duty personnel of the Air Force, Army, and Navy and includes the aeromedical guidelines for those services, is now available on the Apple App Store for the iPhone and iPad. Basically, it’s a mobile, CAC-not-required version of the Flight Surgeon Toolkit from the Knowledge Exchange plus some other handy tools and references that are updated routinely. This app was created by Cpt Colby Uptegraft and can be downloaded for free by searching for Med Standards, Uptegraft, or the App ID #1018687273. More detailed information on the app and “how to” instructions will be in the winter issue of FlightLines. Download the app now and check it out!
So why do flight surgeons fly? Without a doubt, each of us have been asked this question by family, friends, civilians, and military associates... likely the first time we tried to explain what a flight surgeon was. I recently did a “Google search” for “Why do flight surgeons fly?” and the first hit was from the website goflightmedicine.com. On November 2, 2014, Rocky “Apollo” Jedick stated three reasons flight surgeons are required to log a minimum number of flight hours: 1) Aerospace Physiology and Pathology, 2) Unique Demands of the Aircraft & Flying Mission, and 3) Trust. I agree that these reasons are appropriate answers for a test in an introductory class to flight medicine. You’ve got to start somewhere. Now, let’s take this to the graduate level. I’d recommend performing a “search” within yourself and discover why you really fly. Why do you love this job? What makes you passionate about being a flight surgeon? Do you remember the first time you flew...or maybe the first time you piloted an aircraft? One of this issue’s authors compared his initial piloting experience to a bad bowler!—“They tend to launch the ball at the lane. There’s a lot of bouncing and proximity to the gutter. If you have that picture in your mind, you have seen my typical landing!”

This issue will explore the reasons each of us takes to the skies and provide a foundational viewpoint into being an exemplary flight surgeon. Within this issue, you’ll find out why “the flight surgeon should be a combination of doctor, lawyer, and priest” and how to “achieve what...could be considered the most exalted status ANY one can achieve in ANY culture, tribe, or society.” Now I challenge you to find the answers to these questions in the pages that follow. Along the way, you’ll find an issue that is PACKED with fantastic insights into why we should fly, both the pragmatic and the heartfelt.

After you rediscover your motivations and passion for flying, share them with those you work with, share them with your nonflying physician peers, and share this issue! Lastly, share an insight or experience with all of us by sending me an article to publish. Now, get out of the office and fly...you’re a flight surgeon, remember? ♤

**FLIGHT SURGEON CONSULTANT’S CORNER**

Why Do We Fly?

Rob “MOBBIC” York, Col, USAF, MC, SFS
AF/SG Consultant for Aerospace Medicine

<table>
<thead>
<tr>
<th>Question</th>
<th>Year</th>
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<tbody>
<tr>
<td>Q7 - Credibility as physician/clinician†</td>
<td>2008</td>
<td>4.85 &lt;0.001</td>
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<tr>
<td>Q8 - Level of respect as aircrew†</td>
<td>2006</td>
<td>7.81 &lt;0.001</td>
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<tr>
<td>Q10 - Communications skills and efforts†</td>
<td>2008</td>
<td>4.40 &lt;0.001</td>
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<tr>
<td>Q11 - Depth and Breadth of knowledge in Operational Issues††</td>
<td>2008</td>
<td>3.90 0.037</td>
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<tr>
<td>Q11.2 - Flight Safety Issues††</td>
<td>2008</td>
<td>2.56 0.005</td>
<td></td>
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<tr>
<td>Q11.3 - Occupational Health††</td>
<td>2008</td>
<td>2.39 0.151</td>
<td></td>
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<tr>
<td>Q11.4 - Medicine and Medical Practice††</td>
<td>2008</td>
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<tr>
<td>Q14.1 - Demonstrated preparedness for Mishap response/investigation††</td>
<td>2008</td>
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<tr>
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<td>2008</td>
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<tr>
<td>Q15.1 - Flight surgeons’ impact on Flying safety†</td>
<td>2006</td>
<td>0.98 0.944</td>
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<tr>
<td>Q15.2 - Flight surgeons’ impact on Mission Completion††</td>
<td>2008</td>
<td>4.84 0.011</td>
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† Odds of being rating (Superior or Excellent) vs (Good, Poor or No Opinion) in those who fly regularly and frequently vs those who do not.
†† Odds of being rating (Very Satisfied or Satisfied) vs (Neutral, Dissatisfied, Very Dissatisfied) in those who fly regularly and frequently vs those who do not.

Continued on page 4

The views expressed in this newsletter are those of the authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
Being a statistics nerd, I analyzed the data a little further. One of the questions asked “Do your flight surgeons fly regularly and frequently?” Statistical analysis of the 2006 and 2008 survey questions controlling for the flying regularly and frequently variable showed interesting results.

Eleven questions had overwhelming statistical significance, demonstrating flight surgeons who flew regularly and frequently were rated 2.65 – 8.05 times more favorably than those who did not. Broad areas of impact included perceived performance as a physician, communication, flight safety, and mission impact.

The statistic nerd mafia will raise the ecological fallacy question. Does flying make you a high performer or do high performers fly? A fair question, to which there is not an easy answer, but this is my spin – it doesn’t matter. No one doubts a tree falling in the forest makes noise. This is similar for a flight surgeon. We do awesome stuff every day for the line, but if you are not spending time with your flying squadrons, your awesomeness will not be observed. This may diminish the line’s confidence/importance/understanding of what a flight surgeon brings to the fight.

So next time you are asked why you fly, the answer is simple. The line deserves Superior Flight Surgeons, and Superior Flight Surgeons fly. ✪

USAF Medical Service Digest—
Summer 1994
Footnotes...From World War II

Hap Arnold Writes...

Editor’s note: Following are excerpts from a memorandum signed by General of the Army Air Forces Henry H. “Hap” Arnold, probably in late 1941.

This undated draft was discovered by Dr. James Nanney, Air Force Surgeon General’s Office chief historian, in a volume of World War II documents stored in the Air Force Medical Operations Agency physician assistants’ office. On February 3, 1942, Arnold directed only medical officers who demonstrated such field and leadership qualities should be assigned as unit and installation surgeons.

A personal message to all aviation medical examiners and flight surgeons from the commanding general of the Army Air Forces:

The problems inherent in flight call for the practice of preventive medicine in a sense not conceived of by the other branches of medicine. In order to fulfill the requirements in preventive medicine, the flight surgeon must have keen, intelligent and sympathetic insight into the problems, trials and tribulations of each member of his organization...

The first and primary duty of the flight surgeon in connection with flying personnel is the maintenance of the pilot in such condition that, as far as the flight surgeon is concerned, the pilot is always ready for his mission, whatever its nature might be. This is accomplished in numerous ways, such as:

- The winning of their confidence.
- Their care when they are ill.
- Participation in their activities.
- Participation with them in their flying.
- Supervision of their hours of work, relaxation, and messing.
- Judicious cautioning when conditions warrant, with advice to fit the need.
- Having the depth of understanding that will of necessity draw the pilot to the flight surgeon during any period of stress or when his services are needed.

To win pilots’ confidence, the flight surgeon must have dignity and poise, be well-rounded in medical and military subjects so that his decisions are accepted no matter if they be adverse and that his judgments be respected.

In order to care for the pilot who is ill, the flight surgeon must be a good doctor, well-grounded in medicine and with a sympathetic understanding of the patient and the potentialities of the illness, personally, administratively and financially.

The flight surgeon should have an interest in athletics, attempting to make himself proficient in those games in which pilots normally participate. He should have a degree of dexterity and nimbleness so that he may participate in athletics regarding the proper amount and kind of exercise without awkwardness. He should advise the Commanding Officer regarding the proper amount and kind of exercise to enable both air and ground echelons to establish and maintain a degree of physical fitness that is necessary to the war effort.

He should observe the off-duty periods of all personnel under his supervision, with special reference to excessive indulgence, loss of sleep, and any other habits which might be detrimental to the individual’s health, and consequently interfere with the individual’s ability to perform his mission.

The flight surgeon should know the inherent stresses and strains produced by the particular type of flying being done by his group and their effects on the various personality types of his group.

The flight surgeon should be interested in all phases of a pilot’s work and he should have an estimate of each pilot’s capacity to stand fatiguing and long hours...

The flight surgeon should always be prepared to make remedial recommendations [to his Commanding Officer] so that the efficiency of the pilot does not suffer. This can usually be done by an investigation of the individual’s recreational activities and what he does during his periods of relaxation. If there be situations in the home that are causing difficulties of whatever nature, the flight surgeon must, by tact and judicious advice, seek their solution.

It should be stressed that all flight surgeons should be good listeners.

Finally, the flight surgeon should be a combination of doctor, lawyer, and priest, in order that he may adequately fulfill the manifold functions of his office. ✪
The views expressed in this newsletter are those of the authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
Flight Surgeon Support to United States Air Force Fliers in Combat

David R. Jones and Royden W. Marsh


The physician must know what his predecessors have known if he does not wish to deceive himself and others.
(Hippocrates, quoted in U.S. Armed Forces Med J. 1952; 1:1)

The study of history is mankind’s warning to itself.

The everyday practice and operational applications of U.S. Air Force flight medicine by its flight surgeons at the end of the 20th century comprise a system of medical care and support that is unique in human history. Today this system of preventive, occupational, clinical and participatory medicine seems so natural that modern aviators and flight surgeons may take it for granted, having little understanding of the manner in which it developed and matured. Yet, one may fairly argue that military aviation as we know it today would not be possible without its flight surgeons.

...one quickly perceives that the lessons hard-learned in past conflicts—and sometimes forgotten and relearned—are of use in current operations and quite probably will remain so in any future situation where flight surgeons must support USAF fliers in times of crisis. Every war is different, but some aspects seem never to change. Examples of the consequences of not providing aeromedical services provide a clear justification for the existence of the flight surgeon system. Such examples—succinct “lessons learned”—may prove useful in times of cutbacks in personnel and funding.

What is unique about Air Force flight medicine? Its practitioners, the flight surgeons, practice an art that includes, but transcends, the age-old art of therapeutic clinical medicine. Flight surgeons diagnose and treat illness, the traditional role of physicians. They also examine and identify among individuals who wish to fly those who are physically and mentally fit to fly. Once the Air Force has trained these candidates and qualified them as aviators, the flight surgeons must assist in maintaining their fitness, affirmed by continual informal surveillance and periodic formal certification. As we will see, this affirmation of fitness goes far beyond simply having fliers who are “healthy,” since not all healthy people are fit or motivated to fly. Fitness to fly in the Air Force includes, for example, being trustworthy to control hugely efficient and deadly war machines. Today’s combat and combat support aircraft demand the utmost in physical mastery in unforgiving circumstances, plus the skill, judgment and insight to be trusted with weapons of mass destruction never experienced by the human race. Just as maintenance personnel keep aircraft fit to fly and fight, so flight surgeons, like athletic trainers on a championship team, keep their aviators in top shape for action.

Military flight medicine involves another unique element: risk to its practitioners. Consider the ordinary stressors of anyone’s life. Add the stressors of aviation. To these, add the special rigors of military aviation. Now add the stressors of deployment. Finally, add the stressors of flying combat or combat support missions, with their intrinsic possibilities of sudden death for self or others. These stressors comprise an unfortunate but undeniable element of an aviator’s war. Military flight surgeons, unlike civilian Aviation Medical Examiners, are required to meet approximately the same physical and mental standards as their fliers, and to enter the professional arena of aircrew members by participating with them “in regular and frequent aerial flight.” These dry words have remained unchanged since they appeared in 1912 as part of the first U.S. Army regulation establishing formal flying status. As surely as the fliers place their lives and careers in the hands of the flight surgeons in the arena of medicine, so the flight surgeons place their lives in the hands of the fliers with whom they take to the sky. The designation of “flight surgeon” came into being in 1917. Little more than a year later came the first death of a flight surgeon in the performance of his duties when Major William Ream died in a mishap. Since then, ninety-one flight surgeons have died in aircraft with their aircrew: thirteen in combat and the rest in mishaps, either in declared wars, the Cold War, or in peacetime training and familiarization flights. No other medical specialty—and aerospace medicine became a recognized medical specialty fifty years ago—presents such a risk to its practitioners.

Military flight medicine demands knowledge of the disciplines of medicine, the military, and aviation. The mission of flight surgeons who support combat operational units is to keep their fliers safe, healthy and effective so that they can fly, fight and win... The record clearly demonstrates that physicians trained in the principles of aviation medicine and assigned to flying units to care for the fliers can contribute in specific ways to unit safety and effectiveness. Improvement in safety and effectiveness can be measured by objective changes in unit statistics... These results have been corroborated by the contemporary judgment of responsible line officers at all levels of command since September, 1918, when the first flight surgeons joined flying units of the American Expeditionary Force in Europe.

Several specific military aeromedical principles have evolved. History demonstrates that aeromedical authorities should obtain the support of line commanders within the chain of command, train competent and motivated volunteer medical officers to be flight surgeons, and assign them to specific operational flying units at the squadron level as their primary duty. Line commanders should billet flight surgeons with their fliers, give command support to the necessary aeromedical decisions that assure operational safety and effectiveness, and use periodic rest as a powerful counter to flying fatigue in combat situations. Flight surgeons should be active in the unit environment, provide necessary preventive and therapeutic medical care, fly with their fliers in the operational environment to assure mutual familiarity with the immediate flying milieu, and share the experiences that encourage unit cohesion.
In traditional terms, military forces in any combat situation attempt to break the enemy’s will to resist, to demoralize the foe in order to win. In medical terms, this is an effort to induce stress-related symptoms in an opponent who is attempting to cause these same symptoms in our troops. Operational flight surgeons support their fliers by supporting and strengthening their health, hardness, resilience, will to carry on and resistance to the stressors of combat flying. Such medical efforts, once termed “mental hygiene,” are now considered a part of military preventive medicine.

We propose the hypothesis that the professional services provided by flight surgeons have a measurable and beneficial effect upon the safety, health and effectiveness of flying units in time of war. The success of aeromedical efforts may be measured indirectly in several ways: by changes in accident rates, by mission effectiveness, by days lost from flying duties for various causes, or by assessments of morale (itself a difficult task). Because non-medical factors (enemy action, weather, maintenance) certainly affect these factors, one may not easily achieve a clear determination of the effectiveness of aeromedical programs.

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**From the Archives**

**Address to Graduating AMP Students**  
*Reprinted from FlightLines Fall 2001*

**Hadley “Iguana” Reed, MD, MPH**  
**Col (ret), USAF, MC, CFS**

I decided that this might actually be my last chance to talk to an entire class of future Flight Surgeons. I consider this an ENORMOUS opportunity – one I would NOT pass up if I was physically able to show up. This should tell you something about how important you folks really are, or at least, can BECOME.

And as I pondered this precious opportunity, I wondered if I should seek to inspire you with tales from great heroes gone by.

To speak to you of Musashi – declared to be the greatest samurai in the entire long history of Japan, revered even today as the “Sword Saint,” possessed of mythologic skills as a swordsman who embodied the great ideal of the fully integrated man, declaring in his writings that his life’s goal was to have “pen and sword in ONE accord.” And he lived out that extraordinary life and today is held by an entire nation as the greatest Warrior-Artist their entire history has ever produced as a nation of warriors and poets and artists.

Or tell you of Horatius at the Bridge – when a great army stood outside the gates of Rome with slaughter, rape, fire, and pillage on its mind and ONE bridge yet remained across the river Tiber, the river that was the only barrier that stood between Rome and her enemy – and that bridge still stood open to let them in. Horatius, the Captain of the Gates, saw the need, and he cried out these words:

> To every man upon this earth  
> Death cometh soon or late,  
> And how can man die better  
> Than facing fearful odds,  
> For the ashes of his fathers,  
> And the temples of his gods.

And with 2 others at his side, he went across that bridge and at its narrow entrance HE HELD BACK that army of hundreds of thousands long enough for the city fathers to HACK that bridge down BEHIND him alone, cutting HIM off on the WRONG side of the river – he refused to race back across before the bridge fell BECAUSE he was determined to not let ANY get past him as long as that bridge yet stood. And he held that bridge until at last, wounded, he fell into the river. Simply put, he saved Rome.

Or perhaps I should tell you of Cincinnatus, also born of the ancient Republic of Rome, who upon being offered the Dictatorship of Rome for his brilliant service in leading its defense against its enemies, scorned the offer to end the Republic he had fought to preserve, and simply declared he was returning to his farm and that they should give the Republic back to the people. And he did this TWICE in his life – each time showing the true heart and nature of the ultimate citizen-soldier: ready to serve, but REFUSING to RULE the nation he loved.

But then the levels of chemo must have momentarily dropped, probably between hanging bags, and I realized that what I really wanted to do was to share with you what my own heart’s deepest desire for each and every one of you is.

> It’s really quite simple.  
> My heart’s desire for EACH of you is that you become REAL Flight Surgeons.

We all want to experience a level of scrutiny never before received outside of our profession.

We all know the usual dog-sniffing-dog routine we put each other through when we get to a new hospital or clinic – “So, where’d you go to medical school?... So, where’d you train...? Ah... Bob’s Feed Store and Medical Jr College? Why, uh, NO, I don’t believe I don’t believe that I ever DID hear of that one... ahem...”

We all want to know without really coming out and asking, “So, do you really SUCK?” or, “So, are you any darn GOOD?”

For us, it’s mostly a matter of wanting to know how much trouble are you going to add to MY practice OR how much blessing will you bring to my day because you’re someone to whom I can refer stuff I don’t know what to do about...

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BUT, outside our own closed medical tribe, we are used to complete strangers just willy-nilly walking into our offices and plunging down their lives into our hands.

At best they might look at the papers hanging on our walls – but WE know that THEY know they have NO IDEA what it is they are looking at or looking for...unless you happen to be twisted enough to frame and hang that warm congratulatory letter to you from Dr. Kevorkian welcoming you into the Mengele Medical Society.

But NOW – you will be scrutinized – continually – and NOT just in the reassuring confines of YOUR own tribal home territories, where the odds are all in your favor.

Your aircrews are going to scrutinize you in their Tribal Territory, TOO.

And it is RIGHT that they do so.

Why? Because by YOU wearing THOSE WINGS, YOU are declaring to them that YOU have a RIGHTFUL PLACE among their number and that THEIR tribal territory is and should be YOUR territory, TOO; that what you PERSONALLY bring to their world, in fact, has value and relevance to them, to their squadron, and their mission. And before they agree to such a proposition, they want to know if you are worthy.

WHAT?? How DARE they!! Don’t they know – I’M a DOCTOR???

Yeah. They do. Big fat hairy deal.

They ALSO know – just like WE do, that the MD after your name ONLY proves ONE thing – you managed to pass a bunch of tests. It does NOT guarantee that you ARE, indeed, ANY DARN GOOD AT IT.

Gasp!! Our secret is OUT! Oh NO!! What’ll we do NOW?!!

Don’t panic.

The answer is simple yet scary. You must LIVE your LIFE before them. And NOT just that professional “Doctor Face” you flash at strangers for 15-minute intervals. I mean your REAL life. YOU are gonna travel and live and eat and sweat and rejoice and grieve and even fear with these people BOTH at home base and when you deploy with them away from family and clinic and all those familiar surroundings. And you will do this for WEEKS or even MONTHS at a time.

And HOW you live your life as you do all those things will constitute the raw material for their assessment of you AS a Flight Surgeon.

They are usually willing, initially anyway, to take it at face value that you have a reasonable level of competency.

Why?

Because those of us who have come before YOU spent our lives nurturing that expectation before you got here.

THAT is our legacy to you.

THAT is MY legacy to each of you here in this room. It really is all that I have left to give you.

DO NOT FORNIMATE WITH IT.

But beyond that?

They will watch and wait and judge you on your own personal merits, your demonstrated character.

The SAME as they do with each other.

THAT is a compliment; TAKE it as one.

But how will they do that, upon what criteria will they judge you?

Med school placement? Uh-Uh.

Board scores? NOPE.

Warm letters of recommendation from leading residency attendings? Alas NO.

It will be the same criteria by which they judge each other – a criteria of personal character:

They want to know if YOU are a person THEY CAN TRUST.

Do you keep your word?

You will prove this when you show up ON time EVERY time to EVERY briefing – NO “unannounced no-shows,” NO dragging in “just a couple of minutes” late to meetings and briefings. You see, THEY live their LIVES BY THE MINUTE. I have entered target areas flying in the F-111 with only MINUTES of spacing between us and ANOTHER jet that is ABOUT to fly through that SAME airspace.

You see, MINUTES are LIFE in the air. WHY the heck do you think they HACK those watches?? Because it looks COOL?? They NEED to know if YOU understand how LIFE can hang on such tiny increments of time.

You also will prove this by NOT blithely making promises you cannot keep – and keeping EVERY one you DO make even if it means staying ‘til midnight to GET that AMS written and faxed/e-mailed the day you said you’d do it BECAUSE you SAID you would.

OR just to call them back on that lab test on their kid that YOU know is just routine and overwhelmingly likely to be normal – but all THEY know is that it’s THEIR KID.

OR by admitting “I DON’T KNOW, BUT I’ll find OUT and call you back ASAP and you, in fact, DO.

You see, if they KNOW that YOU are someone who is HONEST and who KEEPS their word, they will accept your DNIFing them because YOU SAID you will move heaven and earth and return them as SOON as YOU CAN – that IF there is ANY chance for a waiver, you will STALK that chance down like a starving man HUNTS for a Happy Meal and you will FIND it and capture it if ANY can be found.

If they know you keep your word, they may bitterly regret you’re not being able to get a waiver for them, BUT they will RESPECT you and TRUST you ALL the MORE for coming back bloody and beat up on their behalf in fighting for it.

Why?

Because you KEPT FAITH WITH THEM.

You see, in their world, in their life, they know not every mission is going to be a success, and not everyone always comes back alive...

But what matters to them is that everyone WENT and everyone FOUGHT and everyone GAVE to their UTMOST and held NOTHING back – everyone proved yet again they could count upon one another.

THAT is KEEPING FAITH with each other. THAT is KEEPING FAITH with each other.

And THAT is their unspoken standard by which they will judge you – same as they do for each other.

The GOOD news is you will have ample opportunity to so prove yourself to be such a one EVERY SINGLE day of the week – in a hundred small ways you will be able to show you believe in keeping your EVERY word, and in keeping faith with those with whom you serve.

So what’s the goal? What’s the desired “outcome” of this daily exercise of your personal character?

You will achieve what I believe could be considered the most exalted status ANY one can achieve in ANY culture, tribe, or society – You will become a TRUSTED AGENT. You will discover that you possess a shockingly POWERFUL influence that is and will be TOTALLY DISPROPORTIONATE to your rank OR your degree of medical training.

It is a wonderful, powerful, marvelous, and terrifyingly dangerous thing!
You WILL get furious phone calls from HIGH ranking medical SUBspecialists who, in their frustrated impotent rage, will sputter at YOU over the phone, “Major (or Captain) Smachtzkoff, would you PLEASE tell Lt (or Capt or even GENERAL) Flyboy here that it’s “OK” with YOU that I proceed with MY PLAN to save their LIFE!!!”

And YOU, mind you, will find yourself replying in a respectful but somewhat diffident manner, “Why certainly Colonel, exactly what is it you’re proposing to DO?”

And when he explains it to you, you’ll then find yourself telling that Lt or Capt or General, “Hey, listen Toto, this guy IS the world expert on this so I’d strongly recommend you go along with his plan and I’ll get to work tracking down the waiver issues for you so I can get the lowdown on this for you as soon as you get back, OK? Great! Now, for crying out loud, Sir, PLEASE behave, I have to WORK with these guys, y’know...thanks!”

You will find yourselves at meetings in which you are the ONLY Capt or Maj at a table otherwise completely populated with Colonels with the Wing Commander at the front and he’ll present some pressing issue and ask each one at the table what they think and around the table it’s “Col...,” “Col...,” “Col...,” “DOC? What do YOU think?” and it won’t even be a MEDICAL thing and he’ll nod his cranium as seriously at YOUR answer as he did for ALL those O-6s, MOST of whom have BOXER shorts with more AD service time than you do.

But he’ll listen because you have become a TRUSTED AGENT to that Wing King – he will trust your judgment because he KNOWS you.

Now THAT’S MEDICINE, boys and girls. That’s a kind of medicine that can and does impact the lives of EVERY man, woman, and child on an entire BASE – more people than you could EVER hope to see one at a time in your clinic.

THAT’S the medicine I would wish for each and every one of you to experience before you’re done.

And you WILL IF you EARN it – you will IF you VALUE it enough to seek it.

Because LONG after anyone ceases to care about your test scores or your papers published in forgotten issues of dust-covered journals, maybe even years after you’re retired from active duty, the people who once BELIEVED in you as a trusted agent will STILL be calling you years after you last laid eyes on them, years after you last even TALKED to them, and they’ll call you to say ONE MORE TIME, “Doc, I got this problem and I’m not sure what to do, so I thought I’d ask YOU about it...”

Because once they learned you could be trusted with their more public peccadilloes, they will now FOREVER come to trust you with their most private problems...

And when they DO, you’ll KNOW beyond ANY shadow of a doubt, beyond ANY possibility of contradiction – that you ARE a REAL Flight Surgeon.

And in doing so, you will have KEPT FAITH with ALL of us who have gone on before you – those whose pictures line the hallways here, whose lives date back to the very DAWN of humanity in flight.

You will have kept faith with those whose names lie etched in bronze, hanging on the wall outside our auditorium – our sacred dead, who died AS FLIGHT SURGEONS, MANY of whom died IN COMBAT to purchase YOUR future and YOUR children’s futures with their own last full measure of faith.

And you will have kept faith with those of us who yet remain, who stand and watch and rejoice at your every success and remain ever ready to offer a ready hand to assist your every struggle.

Because in KEEPING FAITH with US, you will have DONE WELL, my precious comrades in arms. You will have DONE WELL.

Iguana’s Reprise

Hadley “Iguana” Reed, MD, MPH
Col (ret), USAF, MC, CFS

As I reconsider my original words shared with young flight surgeons nearly 15 years ago, I am struck by the fact that they remain as true for me now as they did then—in fact, perhaps even more so.

There have been many changes to the landscape of operational flight medicine in the past 15 years since I first bored an AMP class with those remarks: the rapid growth of UAV ops, the growing development and likelihood of deployment of directed energy weapons in the field, new and more complicated weapons systems, new unanticipated human performance issues galore and, most of all, the dramatic increase in ops-tempo accompanied by an equally dramatic shortage of flight surgeons to meet those demands.

All of these things mean greater pressure being placed on you who now bear the burden of being flight surgeons. And yet, what I hoped to convey in my original words becomes even more important because what I was really talking about at that time was the fundamental issue of character—that character transcended mere intellectual acumen or even clinical talent. The ops environment will often not even allow you to practice to the full extent of your clinical abilities; ask any neurosurgeon who finds him/herself deployed with little more than what any basic GMO flight surgeon might have handy. It doesn’t matter if you have the best most intergalactic talent imaginable if you only have the most basic tools of medicine at your disposal. “WHAT??” you will cry, “Why, THAT’S not FAIR!!” Well, as I often said to my old AMP students, “Welcome to EARTH. You are NOT LIVING on Planet Fair, so stop whining as if you should be.”

And what will make all the difference in such inevitable “unfair” circumstances will be your character—the personal qualities you will always bring with you to any fight. Things like integrity—an adamantine determination to keep faith with all those around you regardless of personal cost—say what you can do, and then do ALL that you can do, every time, all the time—putting others’ needs ahead of your own selfish vested self-interests, even to include “minor” things like your own personal comfort and convenience. Someone once defined the demonstration of your integrity as those things you do when you think no one is watching you.

And patience, offering others the benefit of the doubt and even helping them to “catch up” with you—trust me, YOU are going to want others to make the same offer to YOU before you are done.

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The views expressed in this newsletter are those of the authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
And a well-developed, self-deprecating sense of humor—it’s long been the observation (like for a couple of THOUSAND years) that a practiced willingness to NOT take yourself too seriously can contribute immeasurably to the morale and unit integrity all around you, not to mention enabling others to work better with you for everyone’s sake.

And a calm demeanor in the face of obstructions, shortages, stupidity, “unscheduled” dangers and disasters, and all the other manifestations of general human buffoonery that will be your lot to experience in the field (OR in garrison). Usually without warning, and often from those about whom you can do nothing (history teaches that sometimes your enemies are OUTside the wire and sometimes they are INside). So you need to prepare yourself and your response for when such buffoonery arrives on your doorstep like some mangy, sneering dog casually defecating on your welcome mat.

Please note, I said a calm demeanor, this is NOT about what sorts of ugly thoughts you might be entertaining INside your cranium. Just keep that sort of stuff TO YOURSELF. Such a calm demeanor will be of immense value not ONLY to you but to everyone around you—it is remarkably contagious, as I personally can attest having been on the blessed receiving end of such calming influences in the midst of life’s many varied “experiences”—some critical, some merely annoying—I mean, REALLY annoying….like the time this moron...well, never mind. I am sure you have (or will have) your own examples to insert here.

Oh, the list goes on and on and often they are the same things only with different names, but I hope you get my point. Your character will be the only thing you can be sure will always be there with you in the heat of battle, in the moment of crisis, in the quiet of the night, in the calm before the storm—like someone once sagely observed: No matter where you go, there you are.

The good news is that these qualities are learnable, they can be studied and developed and practiced with the laudable (and more importantly) achievable goal of them becoming more and more “natural” to how you react to the vagaries and sudden nasty surprises that life in general, and life in the field in particular, will throw at you.

So, sure, make sure you are a “good doctor” (well, DUH). But I must sadly attest to the fact that there have been a number of cases throughout history (some of which I have observed in person, alas!) of such genuinely “good clinicians” who, when tried in the crucible of life, failed utterly and miserably in their numerous tests of character—as the old story goes, they were “tried and found wanting,” and all their intellectual prowess, all their well-deserved clinical accolades, were for naught, as their lack of character left them unable (or worse, even unwilling) to fully demonstrate whatever “super-keen really cool and w-a-y better-than-yours medical skills” they had expected (and we had hoped) they would show off.

KEY TRUTH: YOU do NOT have to be one of those. A smart person learns from his or her own mistakes, but a WISE person learns from someone ELSE’S. I would more than anything like to see you all become wiser. Heaven knows, you are already mostly too dang smart for me as it is anyway.

Selah,
The Iguana
STAMPED: “GREEN HORNET”

PART I

An Evolutionary Story of the Modern
USAF Flight Surgeon

Johann “Doom” Westphall, Col, USAF, MC
Chief Flight Surgeon

The following official request was recorded by the Chief, Flight Medicine, Aerospace Medical Consultant, Office of the [USAF] Surgeon General:

SUBJECT: Missile Badge Award Request

To: USAF OEHL/CC

Date: 23 July 1982

1. IAW AFR 35-42, Table 1, Note 7, request I be awarded the Missile Badge, as having served at least 3 years in a position directly involved in the R&D, test and evaluation of the Titan II Missile Weapons System.

2. From 1 Apr 60 through 31 Aug 61 I served as the first Consultant in Health and Safety to the Commander, HQ BSD (AFSC), preparing T.O.’s on toxicity of noncryogenic propellants used in the Titan II.

3. <Additional supportive information> //Signed//

R.T.P.deT, Colonel, USAF, MC
Consultant, Occupational Medicine

A response “FOR THE COMMANDER” in August 1982 by the Chief, Aviation Service Branch, Directorate of Personnel Program Actions, bluntly stated:

The attached request for the award of the Missile Badge to Col R.T.P.deT cannot be supported. His duties performed are clearly supportive in nature and IAW AFR 35-42 do not qualify [him] for the award of the badge.

Colonel Touhey’s final action was to report the following to the AF/SG and Colonel R.T.P.deT:

Request is returned without further action as noted above [memo].

And that should have been the end of it – a seemingly innocuous, straightforward, and direct decision not to award a missile badge to a physician in the AF Medical Service. But history, as defined by Barzun, would not relegate this memo to an ignominious end. Instead, in the margins of that memo are written the following unattributed ghost scribblings with this admonition:

Predictable! Did we not learn from [our] past? Remember GREEN HORNET!!! C.F.S.

The point made by this C.F.S. (presumed to be a prominent Chief Flight Surgeon of the era) was that history – especially the history of the USAF Flight Surgeon – was of such paramount importance that it should never be lost or forgotten lest “newborn babies laugh at the old jokes over and over again.” The history of the modern day flight surgeon, as vested and represented by today’s flight surgeon wings, is GREEN HORNET – an evolutionary, a revolutionary backstory, temporarily forgotten until now.

“In the beginning…” and with the establishment of a separate USAF Medical Service in July 1949, no immediate change was necessitated with regard to Army policies pertaining to flying status, ratings, and designations. On 30 November 1949, there were 24 Aviation Medical Examiners (AMEs), 232 Flight Surgeons (FSs), and 142 Aircraft Observers (Medical) (AOMs) on flying status. Additionally, there were many more AMEs, FSs, and AOMs not on flying status but who were serving side-by-side, seamlessly, with their rated colleagues. Graduates of the Aviation Medical Course (6 weeks) were required to complete a 3-month period of preceptorship prior to being designated AMEs. Beginning with AME Class 52B (1952) and after completing an 11-week course, graduates were designated AMEs.

From 1 July 1949 until the new ratings were approved in 1956, the requirements for designation as an FS (crewmember) included at least 1 year on flying status as an AME and 100 flying hours or successful completion of the Basic Course in Aviation Medicine (40 weeks). The Basic Course was interrupted for 2 years by the Korean War and reactivated as the Advanced Course in Aviation Medicine (1 year) during 1952. The AOM rating required 5 years on flying status as an FS, a minimum of 500 hours flight time, and successful completion of the AOM examination. Up until 1956, the AOM was considered the pinnacle of professional (operational) prestige and experience for the aeromedical physician.

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New ratings were established to replace the rating of AOM and the designation of FS on 20 July 1956. On that date, the Chief of Staff approved the new badges and rating for Flight Surgeon, Senior Flight Surgeon, and Chief Flight Surgeon. It is noteworthy, however, that in 1955 a Command Flight Surgeon badge with a wreath was proposed, but so closely resembled the Command Pilot badge that a banner was proposed (and accepted) to replace the wreath and the term Chief Flight Surgeon was adopted.

In the Appropriation Act of 1961 (PL 86-601), Congress imposed a DoD ceiling on the number of rated officers. The AF Surgeon General was given a ceiling of 728 FSs on flying status, at a time when there were over 804 FSs as of 30 June 1960. In the ensuing year, Chief Flight Surgeons in each command and every level discussed and subsequently adopted a strategic plan to argue against the restrictions of rated flight surgeons and consolidate aerospace medicine under one unifying and historical symbol. The plan stagnated in the bureaucratic machine of the day, until April 1954, when Brigadier General (Dr.) Otis Benson, Director, Medical Staffing and Education, recommended the following:

Recommend that the present two (2) badges authorized Flight Surgeons and Aircraft Observers (Medical) be eliminated and a new system of badges for Medical Officer, Aviation Medicine, AFSC 9356, be established. Recommend also that the eliminated designations, Aviation Medical Examiner, Flight Surgeon and the rating of Aircraft Observers (Medical) be replaced by new rating of Flight Surgeon, Senior Flight Surgeon, and Staff (or Command) Flight Surgeon.

This proposal by General Benson ignited an internal, three-decade debate as to the value and description of both the AME and the FS. In an internal AF/SG memo dated 16 December 1958, Major (Dr.) Douglas gently reported:

On 17 April 1958 a letter was sent to the commands, reminding all concerned that AMEs were not eligible to wear the Flight Surgeon’s badge. This policy statement has generated many comments, both verbal and written. In order to provide for better rapport between aircrew members and aviation medical officers it is suggested that a distinctive insignia be developed for graduates of the AME Course. It is suggested that this insignia consist of a pair of wings, joined at the wing root with a superimposed staff of Aesculapius. It is further suggested that the title of Aviation Medical Examiner be changed to Aviation Medical Officer. Such a change in title would give added stature to the position occupied by AMEs.

In June 1959, the Executive Comptroller of the USAF, Colonel S.J. West, weighed in with his office’s support of a distinctive badge for the AMEs and that he was in favor of a design “similar to that prescribed for Flight Surgeons.” Curiously, he concluded his comments in support of an AME name change “…similar to Flight Medical Officer <that> would place the emphasis more properly on their qualification and should enhance the rapport between aircrew members and Aviation Medical Officers.” Throughout this period of tumultuous debate, and in response to reports of varying use and abuse of the flight surgeon wings, Brigadier General (Dr.) Victor A. Byrnes, Director of Professional Services (AF/SG), made the following Air Force policy unequivocally clear:

Flight Surgeon’s badges will be worn only by medical officers possessing the appropriate rating. This policy applies to all Air Force installations both within the continental limits of the United States and overseas.

By 1960, the debate took on a decided focus and unifying consensus that physicians serving in the capacity of aircrew support (AME/FS) needed to be recognized with a distinctive title and badge. In an strategic policy put forth by the AF/SG office, an AFCSG message (929/60), dated 29 June 1960, changed the title of Aviation Medical Examiner to Flight Medical Officer (FMO) and increased the requirements for rating as Flight Surgeon to 200 or more flying time and 2 years’ service on flying status as an AME/FMO. The change in title was adopted to better identify physicians practicing squadron level aviation medicine; the increase in requirements was a means of maintaining the number of rated FSs within the ceiling imposed by Congress. Colonel (Dr.) Charles H. Bramlitt, Deputy Director of Professional Services (AF/SG), put it this way in a memo dated 22 December 1958:

It is further suggested that the title of Aviation Medical Examiner be changed to Flight Medical Officer. This change in title would give added stature to the position occupied by AMEs. It will be recalled that the majority of persons practicing Aviation Medicine at present are AMEs. The Term Aviation Medical Examiner is in reality a misnomer in examinations only and is not qualified in the other aspects of the practice of aviation medicine.

In July 1960, however, a backlash from senior FSs halted the granting of Flight Surgeon rating until further notice and indicated that further requests for flying status orders on all rated medical personnel would be processed at HQ/USAF level. Articulated in a 1959 memorandum by Lieutenant Colonel (Dr.) Henry L. Jones was the following concern:

The term Flight Surgeon, among other attributes, imparts the unmistakable understanding and distinction of a medical officer who holds an aeronautical rating. Symbolic of this or any other aeronautical rating is the insignia that identifies the individual’s rated specialty. These insignia or “wings” are badges of accomplishment and denote successful completion of a formal course of training and full qualification for an aeronautical rating. To permit Aviation Medical Examiners <or FMOs> to be identified as Flight Surgeons would not only be misleading but would set a precedent which, conceivably, could weaken the esteem and prestige inherent in the history of aeronautical ratings.

By the mid-1960s, both the AME and AOM had given way to the FMO and FS ratings. A letter dated 23 October 1963 to Major General Bohannon, the Deputy Director of Professional Services (AF/SG), summed up the two-decade debate accordingly:

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With the change over to the new types of Flight Surgeon badges [FS, SFS, CFS] in 1956, inconclusive efforts were made to provide the AMEs with distinctive identifying badges. In 1960, when the term “Aviation Medical Examiners” was replaced by the term “Flight Medical Officer,” determined efforts were made to have a distinctive badge for FMOs developed.

By 1966 aerospace medicine was composed of FSs and FMOs. It was estimated in FY67 that of the 1,106 <flight surgeon> billets, only 524 rated FSs were available. To fulfill the needed requirement, the remaining 582 spaces were filled with FMOs. And just like the AMEs in the previous decade, the re-casted FMOs were now providing direct medical support for flight operations. Once again, there came an outpouring of support, mainly from FMOs and aircrew from the field, to provide a distinctive badge for these frontline aircrew physicians. Because many of the FMOs were physicians on a 2-year tour of duty prior to separating or moving on in other medical specialties, all were not eligible for the rating of flight surgeon during their tour.

The average background of a 1960’s FMO included 4 years of premedical training, 4 years of medical school training, 1 year of internship, and 8 weeks of Air Force sponsored training in aerospace medicine. Upon graduation from the Primary Course in Aerospace Medicine at the School of Aerospace Medicine, the FMO was normally assigned to duty at the squadron level. To achieve maximum rapport with the aircrew, many FMOs, with support from their local flight surgeon, identified themselves with the flight team by wearing the flight surgeon wings. Between 1960 and 1966, multiple queries and reporting from the major commands indicated tolerance for this practice. In a loosely, yet authoritative memorandum by Colonel (Dr.) Robert Nuernberger, Deputy Director of Professional Services (AF/SG), a compromise to the unauthorized use of the flight surgeon wings was floated:

On 18 October 1962, the Director of Professional Services was requested to suggest to the Command Surgeons that they exercise the option contained in para 102c.(2), AFM 35-10. This authorizes local base commanders to permit use of name plates by their personnel during duty hours. The name plate in question would include the doctor’s name and “Flight Medical Officer.” An article to this effect was also published in the Medical Service Digest. This is not an adequate solution to the problem but appears to be the best that can be provided at this time. Continuing efforts will be made to resolve this problem, although there is no reason for optimism at this time.

In spite of that lack of optimism, another strategic thread was simultaneously being worked within the AF/SG office’s senior leadership. In a 15 October 1963 letter to Major General R.L. Bohannon (now AF Deputy SG), Brigadier General (Dr.) Alonzo A. Towner wrote a revealing “way ahead” for the conglomeration of the FMO and rated FS insignias.

The lack of some type of aviation badge for FMOs has long been recognized as a deficiency item of importance in the development of closer rapport between flyers and flight medical officers. The adoption of an Air Force Aviation Badge for Flight Medical Officers is highly recommended to increase the prestige and morale of these physicians who support our operational flying missions. It is recommended that the Aviation Badge for FMOs, if and when adopted, closely resemble the current wings worn by Flight Surgeons. An acceptable badge for consideration might be the Flight Surgeons’ Wings with the letters FMO super-imposed over the caduceus on the shield.

The constant stream of inquiries and support from the field to have FMOs duly recognized and equitable with their FS (rated) counterparts prompted this unique outburst from Lieutenant Colonel (Dr.) Robert K. Quinnell, Chief of the Aerospace Medicine Division, 2 October 1964:

Addressed to his superiors, Lieutenant Colonel Quinnell continues:

Despite the name plate suggestion and the persistent turnaround by the Permanent Uniform Board, the notion prevails that we need to do something else for the FMO. This current letter [in response to a senior Colonel] is but another tactic in the same battle. Any serious proposal to authorize the wear of the current Flight Surgeon’s Aviation Badge by those not yet qualified by our own standards (i.e., 2 years + 200 hours) will be met with as much resistance from me as I can muster.

Not to completely shut the door to his commanding officers or commit career suicide, Lieutenant Colonel Quinnell offered these final words on the matter:

If our standards for becoming a Flight Surgeon are to be changed, then that is a different matter and I would agree to a return to the 1-year requirement. It should be pointed out that no line officer obtains an aviation badge so easily. Pilots spend a year of intensive training before they are permitted to wear a badge. Similarly, the navigator goes through a lot more than 8-9 weeks of school.

Lieutenant Colonel Quinnell recognized that he was in the minority opinion on the unsanctioned “wear” of the FS wings by FMOs, yet he received unexpected support by means of an authoritative letter titled “Flight Medical Officer Insignia,” dated 21 May 1965, that indicated that the Surgeon General recognized the need for the FMO to receive appropriate recognition without the possibility of reducing the professional qualifications for the FS rating. On 27 December 1965, the Surgeon General submitted a proposal to the Permanent Air Force Uniform Board urging that a
A Salute to 901s

Col (ret) David Jones

Originally published in Winter 1998

In December 1998 I read a message on the Aeromedical List from a U.S. Navy aeromedical technician, Mark Kasehagen, who was stationed at Yuma, AZ. Mark wrote of his experiences in his career field, the lessons he had learned, and some ideas he wanted to leave behind for his colleagues as he retired. He also had some personal and complimentary things to say about the Flight Surgeons with whom he had served. Reading the wisdom he expressed and the responses he generated sure rang a deep chord in this old Air Force Flight Surgeon.

I was 25 years old when I came onto flying status in 1960 as an Aviation Medical Officer (a now-extinct old term for a fledgling Flight Surgeon). Within 7 weeks I was in command of the office, and for the next 15 years I went from one such job to another…Lackland, Brooks, March, Myrtle Beach, Nha Trang, Randolph, and a lot of T DYs and NATO rotations as well. My flyers flew for ATC, MAC, SAC, TAC, USAFE, PACAF, and the Rescue Service. My flying time came in such aircraft as T-29, T-33, T-37, T-38, T-41, B-52, KC-97, KC-135, F-100, F-4, AC-47, C-47, C-54, C-118, C-119, C-123, C-130, C-131, O-1, O-2, U-10 (look it up), A-1, Huey, Jolly Green, HH-43, and a bunch of others.

In my day, aeromed techs were known as 901s, and they were the backbone of the Flight Surgeons’ offices, then as now. Many were aviators themselves, on flying status as aeromedical rescue technicians in the old Kaman HH-43 Huskies (call sign “Pedro”) that were assigned to every flying base for firefighting and crash response duties. During the many years of the doctor draft, the 901s broke in a new crop of young captain Flight Surgeons every year, and they had to show how to invent the wheel over and over and over. They were used to us. Sgt Lebda took me on as a personal challenge in 1960 and was succeeded in the endless job of keeping me straight by a host of others including Sgts Guajardo, Schilling, Chin, Trojanowski, English, Hickey, Banshaw, Know, Jones, Toland, and others too numerous to recall. They were from all possible backgrounds…Hispanic, black, white, Indian, Chinese, and just about all the European countries. They were bone-deep patriots, and they made no jokes about that.

They tended to be just a bit in-your-face, with respect, sir. They knew how to come into my office, close the door, and tell me what to do. They all wanted me to do a good job, whether I knew exactly how to do so or not, and they all had a knack of sort of nudging me toward excellence. They wanted to be able to respect me, if it took them all year. If they didn’t know something, they knew an NCO who did. They would at times use my medical services as trade goods to get a favor from a friend in another organization, and I quickly learned not to ask why this or that non-flyer was sitting outside my office, just see him (or his wife, or his kid).

They all had a friend at headquarters, or on the IG team, and the chain of command was not a matter of awe, but a handy way to get around and get things done. I learned the value of having a quick phone chat as opposed to writing a letter through channels…frequently they would agree in advance on what the resulting letter would say so as to speed its passage. The old boys’ network hummed (no women in the business in those days, though I have absolutely no doubt that since their arrival they have learned the trade as well as we knew it).

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Over the years we went just about everywhere together and did just about anything. I have climbed mountains with my 901s, crossed ravines, and SCUBA dived with them all to recover bodies of fellow aviators (many of whom were friends of mine) from crash sites under the most appalling conditions imaginable. We have laughed a lot, and we have shed tears together. We have slept in, beside, and under the cracker box ambulances. They have winched me up and down from helicopters. We have scrounged C-rats together and know all the tricks of cooking some over open fires in the rain. We have shared many a drink and visited some places of which my mother would not have approved. To inspect, you understand. “You’ve got to see this place, Doc, to see what the troops are up against.” My VD control lectures had a color and authenticity second to none.

They could improvise anything necessary on the spot. I never gave an order, never. I said, “I need…” or “Would you…?” or, more frequently, I never had to say anything at all… it just happened. I always said “Thanks.” From my days as a junior captain through senior colonel they always called me “Doc,” an honorable appellation from their lips worth more to me than any title I can imagine. They were never anything but helpful. We aced inspections for fun, backhand. Their language was crusty, and they knew more and worse jokes than anyone, especially when I had to keep from crying. When I said “OK, Sarge…just don’t get me put in Leavenworth,” we both knew that the job would be done, no questions asked, you can bet your life on it sight unseen. Almost every one of my 901s was promoted during their tour with me, and they all surely deserved it.

I depended upon them utterly, and they never let me down. I would not trade anything for the privilege of having worked with them, and I recognize you well, Mark Kasehagen, though I’ve never met you, and I know all you others who have sent messages to the List and to me personally.

*It’s been an honor to know you and to work with you during the best years of my life, and God bless you all, past, present and future.*

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**From 901 to 4N-F: How to Think Like a FOX!**

Mr. Michael Landez  
Deputy Chief of Medical Standards, AETC

Let’s start out with a little history to show the new 4N0X1F technicians how their career field has evolved. This is a description from Captain John H. Rheinscheld on what 901X0 duties were during the Vietnam War.

The duties of the aeromedical technician are probably the most misunderstood in the Air Force Medical Service. To delineate the duties of those technicians who fly with the HH43B Pedro helicopter crews in Air Rescue and Recovery in Southeast Asia, it may be helpful to describe a typical day with which the aeromedical technician is confronted. Aeromedical technicians at Phan Rang Air Base, Republic of Vietnam, perform a myriad of duties each day. By presenting a typical “alert day” perhaps the importance of the job that these technicians are accomplishing can be clarified.

When reporting for duty at the alert pad, the aeromedical technician becomes a member of the alert crew and, as such, draws his helmet, pistol belt, flak vest, and survival vest. He then proceeds to the aircraft for a survey of his medical equipment and supplies after which he officially relieves the technician who has been on duty for the previous 24-hour shift.

His duty is to stand by, waiting for the call that everyone hopes will never come, but knowing that it surely will. When a crash call is received, the chopper must be airborne within 3 minutes. Therefore, while the rest of the crew is preparing for take-off, the aeromedical technician takes all of the pertinent information over the phone, dashes to the helicopter where he relays the information to the Rescue Crew Commander, and the chopper is on its way.

If the crash call involves a local base rescue, the chopper will drop the fire suppression kit as well as two crash rescue men (flying firemen) and the aeromedical technician as close to the site as possible. The firemen will rescue the aircrew member from the burning wreckage and take him to the medic for first aid. Once the crew member is placed in a litter aboard the chopper, the craft makes a hasty withdrawal from the area to decrease the danger of being hit by enemy fire. Lifesaving measures (airways, controlling bleeding, treatment for shock, etc.) are taken by the medic en route to the medical facility.

If the crash has occurred off base, the firemen are replaced by the crew chief. When the helicopter arrives at the crash site and the downed crew member is uninjured, the jungle penetrator is lowered to pick up the flyer. However, if the pilot is injured and unable to hang on to the hoist, the aeromedical technician is lowered to the ground by the hoist to retrieve the flyer. In all cases, first aid is given on the ground, if possible, and is always administered in flight until the chopper reaches the nearest medical facility. In the event that the medic is on the ground and the helicopter receives ground fire, the chopper takes off, leaving the medic alone with his patient, medical kit, and weapons. Fighter aircraft are then called into the area to lay down a screen of fire between him and the “unfriendly” in the area until he is rescued. In addition to their flying duties, the aeromedical technicians assigned to the 35th USAF Dispensary at Phan Rang Air Base perform routine duties in the flight medicine section and are rotated through the emergency room on a regularly scheduled basis to keep their skills at the highest level.

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The above article (along with loads of other cool stuff) can be found at the following web site: [http://www.901chief.com/chistory1.htm](http://www.901chief.com/chistory1.htm).

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So you see how our career field has changed for the time of the Vietnam War to the duties we now have. I did not serve in the Vietnam War and this was a little before my time as a 901. I entered the service in 1977 and graduated from the School of Aerospace Medicine in December of that same year. I was a 901, 6 weeks and 3 days of training on various subjects such as the atmosphere, emergency medicine, physical standards, etc. Over the last 38 years I’ve seen this career field change dramatically: 901s were allowed to be on flying status when I first came in; it was felt that being on flying status would give you a better perspective of what responsibilities and stressors the aviator went through during flying missions and to understand how certain medical conditions affected the aviator in the flying environment. We also performed rescue/recovery missions when they arose. Around 1982 the Physical Examination and Standards section was developed and the 901 responsibilities grew to not only supporting flyers but also the non-flying population as well. We began processing medical profiles, occupational physical examinations, medical evaluation boards, etc. Even our AFSC changed; we went from 901X0s to 902X0Cs. That was short lived and we went back to 901s. The AFSC changed again to 4F0X1, or what we called ourselves – 4-FOXs.

In 2002 the AFSC took a dramatic turn and was eliminated, and the duties and responsibilities were shifted between two AFSCs: the 4N0X1 (Aerospace Medical Service) and the 4E0X1 (Public Health). There were a lot of challenges with this conversion; however, the two AFSCs managed the programs delegated to them with great pride and professionalism. But as time went on it was felt that there needed to be one primary AFSC that would pull back these duties similar to the 4F0X1 managed programs of the past. In October 2014, the 4N0X-F AFSC was born. With the creation of this AFSC shied come many challenges. To take nothing away from the Flight Surgeon, Aeromedical Technicians were the physical standards masters of the day. Senior technicians taught many of our junior Flight Surgeons the ropes when it came to physical standards. The F shied will need to grow these senior technicians and it will take time. We have a good start with the creation in 2012 of the Medical Standards Management Element and the hiring of civilians who will be the continuity in the Medical Standards Element at each base. The development/implementation of the BOMC is an initiative that is being developed to help the 4N0X1F streamline and reduce error rates in the many programs that they are responsible for in Flight Medicine. There will be many challenges as this new AFSC matures, and I know that times have changed, but I can tell you that my Flight Medicine experience was a very educational and rewarding one and one that I have thoroughly enjoyed for the past 38 years. I highly encourage all 4N0X1F airmen to embrace the challenges that this career path offers, get involved with your Flight Surgeons, know what the AFI’s require, constantly review your processes, and never take anything for granted. Remember, we have always been charged to maintain a fit and healthy force and never forget that you are a key and vital part of this mission. ♠

**Mission Essential Tasks and Line Support (METALS) – A Lost Art?**

Christopher (Toph) “Crush” Rohde, Col, USAF, MC, SFS
AFMSA/SG3PF

As an Air Force flight surgeon, you may often find yourself overburdened with your duties in the clinic. Finding time to fly 4 hours every month can become difficult, especially when you stack on all those pre- and post-flight briefings, crew rest requirements, and associated down-time waiting for delays, broken jets, and administrative burdens. You may lose an entire day and only gain 1-2 hours of fly time for your effort. So, other than flight pay, why do we continue to fly? It is all part of a skillset that flight surgeons have traditionally held that set them apart from other primary care physicians—Mission Essential Tasks and Line Support, or METALS.

METALS may vary depending on your location and your unit’s mission and go beyond flying with your assigned squadron. IAW AFI 48-149, your SGP should create a prioritized list of METALS annually that flight surgeons need to accomplish. These METALS should directly lend support to your line units. Some METALS are mandated by AFI, such as industrial/occupational shop visits, food facility inspections, tower visits, mishap investigations, HUD reviews, and grounding management. The list is long and there is a sample list on the Knowledge Exchange for your reference when developing a list for your installation. The list is under the “Documents” tab in the “Operational” folder, or you can use this link: [METALS List](#).

A deployment in today’s operational environment typically means a 6- to 12-month trip to a large established installation somewhere with lots of sand and bugs (not Col Ortega, but the 6-legged variety). These installations usually come with a full complement of supporting functions including Public Health and Bioenvironmental Engineering. But have you ever thought about the first group to deploy to that location? Before all the tents and hardened facilities? Before Starbucks and Baskin Robbins? We have been deploying to the same locations for so long, most of our junior flight surgeons have never done a site survey or had to develop a location to receive forces. Usually, one of the first airmen to set foot in that location is a flight surgeon. Without Team Aerospace there to assist, that flight surgeon becomes the subject matter expert on all things remotely related to medicine. Where do we set up the latrines? Where should the drainage go? How far should the dining facility be from the drains? Is this a safe water source? What are the hazardous exposures in this location? I’ve got this rash...you know?

While there is nothing like a good deployment to make you an almost instant expert entomologist, industrial hygienist, or Public Health Officer, METALS in garrison prepare us for these questions by providing us with experience and expertise in deployment medicine. As a flight surgeon, you are more than likely the Occupational Medicine consultant for your installation, not just for flight crew members, but for everyone who works on that base. The fact that you take the time to interact with our line brothers and sisters gives you legitimate credibility and makes you a trusted resource. So, it behooves you to go on those shop visits and learn everything you can about the noise level that the aircraft mechanics are exposed to, the sleep habits and schedules of the controllers, how to perform a food service inspection to protect your installation from food-borne diseases, and all the other knowledge that METALS are designed to teach us.

METALS are so important that AFI 48-149 requires that 50% of the flight surgeon’s time be dedicated to performing them. Now that our flight surgeon manning situation has improved to better than 90%, it is time to get ourselves out of the clinic for a while and rekindle those skills that make us flight surgeons. ♠
MQT … on the QT!

Michael “Backdraft” Madrid, Lt Col, USAF, MC, SFS
Chief of Medical Standards, AETC/SGPS

So, you’re the flight surgeon, but are you a qualified flight surgeon?

The question is not whether you are a competent FS or if you have “The Right Stuff” (those are loftier questions), but have you checked all the boxes to be a qualified rated aircrew member who contributes to the mission at home station as well as in the deployed setting? If the SARM/HARM agrees to fly you and log FS hours while only meeting incentive standards, you better point to the “Rated Wings” on your chest and ensure you meet appropriate aircrew standards. Never forget you are a RATED AIRCREW member because those who inspect the flight squadron won’t forget. In addition, local flight waivers may get you flying at home, but there is a high likelihood that in the deployed setting no such waivers will exist. Get together with your SARM/HARM, senior flight surgeon, and MACOM as necessary to ensure you meet all the standards for qualification; or better yet, pull out the AFIs and become an authority on the matter. A good place to start is AFI 48-149, Chapter 9, for mission qualification training (MQT).

SERE water survival is a must for deployment, even though there may be a local waiver for flights that do not overfly water or are with gliding distance of land. For T-38 flights, centrifuge training must have been completed to 7.5 Gs and 9.0 Gs for F-16. There has been some confusion for T-38s since the AETC Supplement states requirements for pilot and WSO but not flight surgeon; rest assured that since you are a RATED FLYER you must meet the WSO SARM/HARM requirements. Below is a list of flight AFIs for reference (also see the cool new Uptegraft FS App for iPhones, which includes many of these references).

<table>
<thead>
<tr>
<th>Topic</th>
<th>AFI</th>
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<tr>
<td>Aircraft-Specific Aircrew Training (for T-1s, T-6s, T-38/T38CIFFs, etc.)</td>
<td>AFI 11-2T-1V1</td>
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<td>AFI 11-2T-38V1</td>
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<td>AFI 11-2T-6V1 etc.</td>
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<td>Rated Aircrew General Training</td>
<td>AFI 11-202V1: Aircrew Training</td>
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<td>AFI 11-290: Crew Resource Management (CRM)</td>
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<td>AFM 11-210: Instrument Refresher Course (IRC)</td>
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<td>AFI 11-403: Aerospace Physiological Training Program</td>
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<td>AFI 11-404: Centrifuge Training for High-G Aircrew</td>
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<td>AFI 13-207: Anti-Hijacking (FOUO)</td>
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<td>Standardization/Evaluation Testing</td>
<td>AFI 11-202V2: Aircrew Standardization/Evaluation Program</td>
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<td>Flight Management</td>
<td>AFI 11-401: Aviation Management</td>
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<td>AFI 11-402: Aviation Parachutist Service, Aeronautical Ratings and Badges</td>
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<td>AFI 11-421: Aviation Resource Management (HARM/SARM)</td>
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<td>Life Support Programs</td>
<td>AFI 11-301: Aircrew Flight Equipment Program</td>
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<td></td>
<td>AFI 16-1301: Survival, Escape, Resistance and Evasion (SERE) Program</td>
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The SARM will help you get all the local requirements such as egress training and cockpit resource management accomplished, but also think about the big flight surgeon picture. Given the increased manning that bases are receiving, it should be paramount to train up the young FS and PREPARE and ENERGIZE them for the future. Identify early those FSs who may wish to pursue the pilot-physician program; get folks to the SERE, centrifuge, AMIP, Occ Health, Prev Med, ... sniper course (okay, my wishful thinking on the last one). Gone are the days at Brooks City-Base where your big ticket qualifications of centrifuge, water survival, and SERE B were completed at the conclusion of the Aerospace Medicine Primary course. Now equivalent training is required, but you need to be proactive in getting it scheduled. 🦅
The Future of Flight Surgeon Flight Pay

Duncan “SLASH” Hughes, Col, USAF, MC, SFS
AFMSA/SG3P

Is the rumor true? Is flight surgeon flight pay going away? We’re just now getting flight doc manning up to decent levels again – loss of the flight pay incentive will decimate all of those hard-earned gains! If these questions and rumors exist in your Flight Medicine shop, then please keep reading. Since I work inside the beltway in DC, here’s my attempt at transparency.

In 2008, the President’s National Defense Authorization Act (NDAA) purposefully streamlined all Department of Defense (DoD) legal pay authorities, thereby stipulating which laws/authorities would be used going forward to authorize the payment of all salaries and incentives, etc. within the DoD. The goal of these changes was twofold: 1) 65 different pay authorities would be condensed into only 8 total pay authorities, thereby simplifying the legal governance, and 2) military service secretary (e.g., Secretary of the Air Force) flexibility would be increased in deciding what to incentivize as service-specific guidance could replace some of the deleted former legal pay authorities. The theory was good; but, as always, the devil was in the details.

When the new Aviation Incentive Pay Authority §334 (one of the remaining 8 authorities) was drafted, the drafters decided to eliminate the verbiage specific to pilots receiving gate pay. That’s right, the issue was about pilots and their gate pay—it had nothing to do with flight surgeons at all. Unfortunately, the paragraph in the old pay authority (§301) that spoke to gate pay for pilots and their gate pay—had nothing to do with flight surgeons. This meant that all the verbiage in the gate pay paragraph applied only to pilots and not to flight docs (i.e., no gate pay for flight docs). When the pilot gate pay verbiage was deleted and not copied forward into the new aviation pay authority draft document, the parenthetical statement about “except for flight surgeons” was still there. Thus, the new pay authority has an “except for flight surgeons” line in it that is completely out of context and no longer makes any sense. Bottom line – my synopsis is that a simple cut and paste error caused the new aviation pay authority to read as if it were meant to exclude flight surgeons. Longwinded explanation – I know – but, best as we can ascertain, that’s exactly what happened.

The good news: the prior pay authorities were all grandfathered in for 10 years (i.e., until 2018) or until the new pay authority becomes law – whichever comes first. The bad news: the new aviation pay authority is set to become law 1 Oct 2015. Needless to say, the headquarters flight med team has been working feverishly ever since 2008 to get this oversight corrected. And yes, getting all stakeholders to agree that 1) there was an oversight, 2) that it now needs to be corrected, and 3) to get a piece of legislation to Capitol Hill and into law is a lengthy, lengthy process!

So Rolex forward to present day. A legislative proposal to fix this oversight and reestablish the legal pay authority for flight surgeons to receive flight pay has been written, coordinated, and successfully submitted to Capitol Hill to be vetted in the law-making process. It successfully emerged from the House Armed Services Committee intact, but the Senate Armed Services Committee (SASC) did some military compensation editing and the version that came out of the Senate committee no longer had the flight surgeon specific verbiage. As always, whenever the House and Senate versions of a bill differ, the two committees will go into “conference” to deliberate on the differences and agree upon the final version of the proposed bill to go forward for signature. That is where we stand today. Congress just reconvened after Labor Day and this is just one of the many issues they have to resolve before the new fiscal year is upon us (e.g., Iran nuclear deal and other such issues less important than flight surgeon flight pay). If the new NDAA is not passed by 1 Oct 15, the DoD will likely go into continuing resolution authority into the near future. In that scenario, the grandfathered “old” pay authority would still be legal as no new pay authority will have become law and replaced it. All information we’ve obtained from our SASC contacts lead us to believe that the flight surgeon specific verbiage in the SASC version of the bill was simply caught up in multiple other edits that were made and that there was/is no intent for it to be removed. Thus, we are confident that the final version of the NDAA bill that emerges from “conference” to go forward for the President’s signature will contain the reinstatement of flight surgeon flight pay into the new aviation pay authority.

We are simultaneously working several other flight surgeon pay issues to include pay for simulator time and pay for RPA ops support, etc. However, we are choosing our battles and timing them in the way that best supports their chances of success and approval. Pending the current NDAA bill language and approval regarding overall flight surgeon flight pay, we will then fence in on some of these other targets.

If you have specific questions on flight surgeon flight pay please contact Lt Col Patricia MacSparran or me at patricia.a.macsparran.mil@mail.mil or duncan.g.hughes.mil@mail.mil.

The views expressed in this newsletter are those of the authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
Flying RAMs: Learning to Fly at Greene County

Chris McLaughlin, Capt, USAF, MC, FS
RAM XVII

“Greene County Traffic. Warrior 5897 Victor. Taking off runway 07 Greene County.” In a matter of seconds I will be airborne with no one else to prevent me from plummeting back to Earth. I should be excited, but the only thing running through my head is “right rudder, right rudder, right rudder.”

Just 4 weeks earlier, RAM-17 gathered in the classroom at Greene County, Lewis A. Jackson Regional Airport for a week of condensed ground school. In only four and a half days, we covered aerodynamics, propulsion systems, instruments, navigation, weather, airspace, regulations, among other topics to prepare us for our ground school exam. Our ground school instructor kept us engaged when our brains were actively liquefying. Somehow, we all managed to learn about torque, prop wash, and p-factor. Would any of us actually apply that correctly?

Today I have the correct amount of right rudder. The middle of the runway is a beautiful thing. It’s something I have rarely seen. Here comes 60 KIAS. I pull back on the yoke and I am in the air. Uh-oh.

I remember my first take-off 3 weeks earlier. That was when my instructor pilot was still trying to make me feel good about myself. “Great job! If you keep flying like that, I’ll have to pay you for lessons soon.” Let’s just say he never had to pay me for lessons. By the second take-off, he was a little more honest. “Whoa! Did you forget about the right rudder? Why’s your nose so high? What’s your best rate of climb?” Honeymoons are so short.

“For weeks my patterns were filled with question after question after question. “What’s your airspeed? Should you be this low? INCREASE POWER!” Okay, the last one was not a question, but I heard it a lot on approach. Until my stage ride with another instructor, I wasn’t sure that I could ever land without being walked through step-by-step. My first landing on that stage ride was strange. I was silent. The IP next to me was silent. My usual IP was not silent. His voice was present in the too soft whine of my power setting. Increase power.

Have you ever watched bad bowlers? They tend to launch the ball at the lane. There’s a lot of bouncing and proximity to the gutter. If you have that picture in your mind, you have seen my typical landing. Still, my stage ride instructor pilot had an oddly comforting point. After 15-20 hours and 30-40 landings, we all have enough skill to get the aircraft close enough to the ground for a survivable crash. Survivable. That’s the key.

I think back to some of the times that I really thought I was going to land, then… “I have the aircraft.”

“You have the aircraft.”

What we really meant in that conversation was, “I am taking the aircraft because I would like to make it home.”

“You have the aircraft because a competent pilot needs to fix this situation.”

“I aim at the 07 on the runway. I am actually heading there. I will not have to go around. Of course, that doesn’t mean that I won’t forget to stop aiming at the 07 and “land” propeller first. That’s right! Don’t land propeller first. Nose up. Look at the trees at the end of the runway. Cut power. Hold the nose יעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעיעע
Fear of Flying

Bob Ireland, Col (ret), USAF, MC, CFS
Former Chief, Neuropsychiatry Function at the Aeromedical Consultation Service, Military Psychiatry Consultant to the USAF SG, and DoD Program Director for Mental Health Policy

A third of non-aviators in the United States are either anxious or afraid to fly due more to emotions while flying than safety concerns. Twice as prevalent in females, such discomfort with flying is correlated with anxiety when exposed to heights. A fifth of the U.S. general population suffers anxiety disorders linked to genes, including panic disorder, social phobia, generalized anxiety disorder, obsessive compulsive disorder, and post-traumatic stress disorder. Such conditions usually rule out consideration for initial flight training and may terminate an existing flying career if treated unsuccessfully.

Should a trained aviator present with symptoms of anxiety or flight phobia, workup should rule out medical causes: substance abuse/withdrawal, endocrine and metabolic conditions, neurological disorders, cardiovascular & respiratory disorders, medication side effects, or miscellaneous conditions as anemia or MSG toxicity.

Flight phobia may be mitigated by a course of behavioral modification involving timely employment of various relaxation techniques usable in a flight setting. Such may involve coordination with flying authorities to procure time in a flight simulator in which to practice techniques and permission to use them in operational flight settings. Cognitive insight psychotherapies may also be employed by psychologists and safely continued after an aviator has returned to flying.

Traditionally, after exposure to highly traumatizing events, American military services employ combat and operational stress control management principles using the mnemonic BICEPS for Brevity, Immediacy, Centrality, Expectancy, Proximity, and Simplicity to reduce acute stress reactions and PTSD.

Aviators with somatoform presentations may be more challenging to assist, although answers to 3 basic questions may reveal whether an aviator is more concerned about being sick or about having to fly:

1. What do you think about these symptoms?
   - Good Motivation: “I’m worried…am I really sick?”
   - Poor Motivation: “I’m not worried about an illness…just ground me and I’ll be OK.”

2. Why can’t you fly with these symptoms?
   - Good motivation: “I’m really sick…how long will it take me to get well?”
   - Poor motivation: “I’m not safe…just ground me and I’ll be OK.”

3. Will you fly when we cure you?
   - Good motivation: “That’s a dumb question!”
   - Poor motivation: “(Sigh) I guess so.”

Aviator disposition pathways are shown below. The results indicate that three out of every four aircrew or special duty personnel referred to the Aeromedical Consultation Service (ACS) due to a history of psychiatric illness/injury receive a recommendation to return to their duties. Major command authorities concurred with 98% of ACS staff recommendations.

Continued on page 21
Decompression Sickness of F-16 Pilot

Johan Ahn, Lt Col, USAF, MC, FS
36 Fighter Squadron, Osan AB, ROK

A male F-16 pilot experienced a rapid decompression during routine pre-flight engine run-up at Osan AB earlier this year. His personal account is in italics below.

I arrived at my aircraft for a pit-and-go ACM [air combat maneuvering] sortie. I started the jet around 0830L and everything was normal until I closed the canopy and the ECS [environmental control system] began providing cockpit pressurization. The ECS turned on normally (i.e., on time/as expected with no weird noises or abnormal airflow); however, when the ECS began pressurizing the cockpit, it never stopped pressurizing. Within seconds the pressure became extremely uncomfortable and it felt like my head was trying to implode. After I noticed the pressure on my head, my ears began to hurt and I needed to Valsalva immediately. I was able to clear my ears but as soon as my ears cleared I immediately needed to Valsalva again and again and again (i.e., I couldn’t keep up with how fast the cockpit was pressurizing). This sensation continued until I shut the ECS off and the cockpit pressurization stabilized. Due to adrenaline/time warp, I’m not completely sure how long this rapid increase in pressure continued for; however, my best guess is 15-45 seconds. Once I shut the ECS off, my ears stabilized but my head was still under a lot of pressure.

I called a red ball for ECS and started analyzing what was going on. (At this time, I had no idea that the cockpit was over pressurized…I just knew that something was wrong and I was in pain but I didn’t understand why.) When I looked at my cockpit pressure gauge, the needle was bouncing between the 4-5 o’clock position, which is an unlabeled portion of the gauge (i.e., I was unsure if the needle spun clockwise [under pressurized] or counter-clockwise [over pressurized]). By this time, the ECS specialist arrived and I explained to him what happened. We agreed that I needed to shut down and step to a spare (again, still had no idea that the cockpit was over pressurized). I coordinated for a spare and began to shut down. I opened the spider-guard on the canopy and I was expecting to hear/feel the cockpit pressurization equalize but I never heard or felt anything and my cockpit pressure gauge was still stable in the 4-5 o’clock position. These two things combined led me to falsely conclude that the cockpit was at ambient pressure and that the cockpit pressure gauge was broken.

As soon as I opened the canopy (0845ish), there was an extremely loud “bang” sound, my ears started ringing, and my inner ear was tumbling forward (i.e., I was spatially disoriented). During this rapid decompression, all of the moisture inside of the cockpit condensed and the entire cockpit turned into a cloud until the canopy raised enough for the moisture to escape. I sat in the jet for a few minutes trying to regain my balance/stop the tumbling. When I looked at the cockpit pressure gauge, it was stabilized at 0’ pressure altitude (i.e., I don’t think it was broken). I got out of the jet and collected my belongings and proceeded back to the squadron. I felt lightheaded and it felt like I was floating when I was walking but I didn’t feel any physical pain (In hindsight, I think I was actually in shock.) When I got back to the squadron I started to take off my poopie-suit and that’s when I noticed that my sternum was hurting enough that I needed to see the flight doc. When I walked down from life support and started walking to the ops desk I noticed that my farsighted vision was blurry and I couldn’t see the end of the hallway. I coordinated with Top-3 to get a ride to the hospital.

0910: Brought to ER by an ambulance and placed on 100% oxygen by 0912 hour. Patient complained of lower sternal pain of 3-5 out of 10, worse with deep breathing. Initial vital signs were normal as was the 12-lead EKG. Chest x-ray at 0930 hour was normal without pneumothorax. MEDEVAC’d to Chungju hyperbaric chamber and started Navy Table 6 treatment after consulting with USAFSAM Hyperbaric Medicine Branch.

References


1155: Began diving to 60 feet.

1320: Chest pain subsided but still had numbness to his right face V3 distribution.

1400: Ascended to 30 feet and chest pain worsened without change to his face or new symptoms. After discussion with the Korean hyperbaricist on site, flight docs decided to continue at 30 feet but dive him back to 60 feet if the symptoms did not improve in a few minutes.

1430: Chest pain improved but the facial numbness persisted.

1432: The face mask was completely removed to rule out its tightness causing numbness.

1512: Face felt better with the neuro check.

1625: Began ascent to surface at 5 feet per minute. Patient was asymptomatic.

1655: Patient taken out of the chamber. Patient was taken home by ground transportation. He was counseled on oral hydration, no exercise, no alcohol, no diving, and DNIF x 3 days. Follow up next morning at the flight medicine clinic.

After I left the chamber and returned home (1930ish) new symptoms began to appear. My back, neck, and head started to ache (a dull pain which wasn’t painful…it just felt like I had an achy body similar to when you have a fever or the flu). I also had a headache and my chest discomfort started to return. Around 2100L, I notice a blister under my right eye but there was no pain associated with it (i.e., it was just a pocket of fluid). I went to bed relatively comfortable but woke up in the middle of the night because I was “leaking urine” (i.e., my bladder didn’t completely empty but I was definitely subconsciously discharging urine). When I went to bed I didn’t have to go to the bathroom, I was only asleep for a few hours before I noticed, and I didn’t feel like I needed to go to the bathroom once I awoke. When I went back to bed, my headache was gone but my body still felt sore. When I got out of bed (0800ish) my headache returned, I started dry coughing an abnormal amount, and my lower back/spine/neck were achy (again, no sharp pains just a dull, uncomfortable sensation). I arrived at the hospital on 6 Feb 2015 around 0930 for a pre-planned check-up/follow-up and described these symptoms to the flight docs.

During follow-up visit in our clinic, patient complained of new lower back and right upper neck pain, 3 out of 10, respectively. He also reported an episode of urinary incontinence last night during sleep as well as mild residual lower sternal discomfort. Denied numbness/tingling in the extremities or groin area. Upon consultation with USAFSAM hyperbaric fellow, we decided on another Navy Table 6 treatment. Prior to treatment, his sensory for vibration, cold temperature, and pinprick was decreased in the right V3 distribution. He denied nausea, vomiting, vision, and hearing problems. Patient limped slightly due to worsened lower back pain after landing at Chungju hyperbaric chamber. The MEDEVAC helicopter ride lasted 30 minutes at 1000 feet or below.

1330: Began diving at 5 feet per minute.

1342: Reached 60 feet below sea level and his back pain resolved significantly immediately. Pinprick and cold temperature sensation returned to normal in the right V3 distribution within the first 20 minutes. Vibration sensation returned to normal within the next 30 minutes.

1457: Started ascent 1 foot per minute.

1527: All symptoms resolved when reaching 30 feet below sea level.

1757: Began ascent 1 foot per minute.

1837: Reached sea level and out of the chamber. His vital signs were stable during the entire treatment.

All neurologic exams were normal without sensory deficit and he has returned to 100%.

My SGP and his superiors decided to categorize this event as “chamber-induced DCS, all symptoms resolved in <2 weeks” and “DSC/AGE categorized as severe, including CNS* or pulmonary involvement.” Therefore, no waiver was required. He was on the ground in his cockpit, not altitude induced. Theoretically, he dove to an uncertain depth for approximately 1 minute and resurfaced in a split second. Since ACS review was required per Table 1 on page 273 of the Air Force Waiver Guide (15 July 2015), we submitted his case via AIMWTS and requested ACS approval for RTFS.

1. Documentation of symptoms and response to recompression therapy. (I submitted his event like a story.)
2. Neurological exam performed by a neurologist or hyperbaricist. (This was performed by an Army neurologist 1 hour away from our base.)
3. MRI (minimum 1.5T unit) within 1 month of episode; images sent to ACS and reviewed. (Complied. Brain MRI without contrast was normal.)
4. Consultation with USAFSAM Hyperbaric Medicine Branch. (We emailed the team requesting their blessing of our RTFS plan, which we received immediately since they were consulted from the beginning of this case.)
5. ACS review required. (ACS documented approval of RTFS via AIMWTS as for all other waivers, but this was not a waiver.)
RAM XVII Class Introduction

Chris McLaughlin, Capt, USAF, MC, FS
RAM XVII

The newest Residency in Aerospace Medicine (RAM) class has arrived. The 2017 RAMs began their 2 years of training at the United States Air Force School of Aerospace Medicine (USAFSAM) at Wright-Patterson AFB on 15 June. Already, the class has completed the Medical Effects of Ionizing Radiation course, finished ground school at the Greene County Lewis A. Jackson Regional Airport, soloed in a Piper (nearly 100% of the class), spent 2 weeks learning about and flying the T-6, and begun intensive instruction on the principles of aerospace medicine. Through that rapid induction to the program, the 11 RAMs have bonded quickly.

The RAM XVII class comprises 11 flight surgeons with a variety of clinical and operational backgrounds. Eight of the residents have prior board certification, with four in family medicine, two in emergency medicine, one in pulmonary-critical care, and one in pediatrics. Two of the general medical officers (GMO) will continue on to the RAM-FM program to gain additional clinical expertise. The remaining GMO will pursue further training in medical informatics. RAM XVII has a full range of flight medicine knowledge, including operational familiarity with fighters, tankers, heavies, gunships, NSAv, helos, rotary wing, and RPAs. The cumulative experiences of RAM XVII include squadron command, chief of medical staff, chief of aerospace medicine, Air Staff, teaching at one of the premier civilian schools of medicine, and the overall exemplary Airmanship that led to a 2-year below the zone promotion to lieutenant colonel. RAM XVII also has the honor of graduating the 1,000th RAM from USAFSAM.

The RAM XVII patch represents its class well. Just as RAM XVII derives its character from the varied experiences and relationships between its members, the patch calls to mind the constellation Aries; for both, the whole is greater than the sum of their parts. The patch’s central image is a stylistic representation of Aries, the ram. The four stars represent both the constellation’s four principal stars and the four services the graduates of RAM XVII will support. Aries’ association with the vernal equinox and historic association with Mars are fitting for military healters, as spring is a symbol for regeneration and Mars is the god of war. Aries’ position as the first constellation in the astrologic calendar is reflected in RAM XVII’s motto of “Primum in Caelum,” or first in the sky. The RAM XVII class will exemplify that spirit by leading the Air Force into a new era in both aviation and medicine.

RAM XVII Class

<table>
<thead>
<tr>
<th>Resident</th>
<th>MPH School</th>
<th>Prior Duty Station</th>
<th>Medical Degree/Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracy Bozung, Lt Col, USAF, MC, FS</td>
<td>Wright State Univ</td>
<td>Pentagon, VA</td>
<td>MD, Family Medicine</td>
</tr>
<tr>
<td>Paul DeFlorio, Lt Col, USAF, MC, FS</td>
<td>Wright State Univ</td>
<td>Wright-Patterson AFB, OH</td>
<td>MD, Emergency</td>
</tr>
<tr>
<td>Ashley Franz, Capt, USAF, MC, FS</td>
<td>Wright State Univ</td>
<td>Grand Forks AFB, ND</td>
<td>MD (RAM-FM)</td>
</tr>
<tr>
<td>Chuck Mahakian, Lt Col, USAF, MC, FS</td>
<td>Wright State Univ</td>
<td>JB McGuire-Dix-Lakehurst, DE</td>
<td>MD, Pulm/Crit-Care</td>
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<tr>
<td>Bryant Martin, Lt Col, USAF, MC, SFS</td>
<td>Harvard</td>
<td>Langley AFB, VA</td>
<td>MD, Family Medicine</td>
</tr>
<tr>
<td>Chris McLaughlin, Capt, USAF, MC, FS</td>
<td>UNC-Chapel Hill</td>
<td>Cannon AFB, NM</td>
<td>MD</td>
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<tr>
<td>Michelle Milner, Lt Col, USAF, MC, FS</td>
<td>UT-Houston</td>
<td>JB San Antonio-Kelly, TX</td>
<td>MD, Family Medicine</td>
</tr>
<tr>
<td>Anthony Mitchell, Lt Col, USAF, MC, FS</td>
<td>Johns Hopkins</td>
<td>UMMS-Shock Trauma, MD</td>
<td>MD, Emergency</td>
</tr>
<tr>
<td>Stefanie Nance, Lt Col, USAF, MC, FS</td>
<td>UT-Austin</td>
<td>Sheppard AFB, TX</td>
<td>MD, Pediatrics</td>
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<tr>
<td>Jaime Rojas, Maj, USAF, MC, FS</td>
<td>Wright State Univ</td>
<td>Beale AFB, CA</td>
<td>MD (RAM-FM)</td>
</tr>
<tr>
<td>Andrew Timboe, Maj, USAF, MC, FS</td>
<td>UT-San Antonio</td>
<td>Nellis AFB, NV</td>
<td>DO, Family Medicine</td>
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RAM XVI Call Signs

In the spirit of RAM and U.S. Air Force aviation history, the 2016 RAM class gathered together for a traditional roll call and naming ceremony. Below is a list of the 2016 RAMs and their new call signs.

<table>
<thead>
<tr>
<th>Resident</th>
<th>Call Sign</th>
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</thead>
<tbody>
<tr>
<td>Elizabeth Anderson-Doze, Col, USAF, MC, FS</td>
<td>Snoozy</td>
</tr>
<tr>
<td>Michelle Brown, Lt Col, USAF, MC, FS</td>
<td>VORTeX</td>
</tr>
<tr>
<td>Tim Duffy, Col, USAF, MC, SFS</td>
<td>BLADE</td>
</tr>
<tr>
<td>An Duong, Lt Col, USAF, MC, FS</td>
<td>Dr. No</td>
</tr>
<tr>
<td>John Hatfield, Lt Col, USAF, MC, FS</td>
<td>NOAH</td>
</tr>
<tr>
<td>Kevin Hettinger, Lt Col, USAF, MC, SFS</td>
<td>MOSES</td>
</tr>
<tr>
<td>Maximilian Lee, Lt Col, USAF, MC, SFS</td>
<td>MASK</td>
</tr>
<tr>
<td>Hui Ling Li, Lt Col, USAF, MC, FS</td>
<td>SWARM</td>
</tr>
<tr>
<td>Joanna Nelms, Capt, USAF, MC, FS</td>
<td>BOOSTER</td>
</tr>
<tr>
<td>Benjy Park, Maj, USAF, MC, FS</td>
<td>Double</td>
</tr>
<tr>
<td>Vanessa Pearson, Capt, USAF, MC, FS</td>
<td>Rascal</td>
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<tr>
<td>Paul Puchta, Lt Col, USAF, MC, FS</td>
<td>Enigma</td>
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<tr>
<td>Kevin VanValkenburg, Col, USAF, MC, FS</td>
<td>Eeyore</td>
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<tr>
<td>Jennifer Wolf, Maj, USAF, MC, FS</td>
<td>EWOK</td>
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<tr>
<td>Tory Woodard, Lt Col, USAF, MC, SFS</td>
<td>SHOT</td>
</tr>
<tr>
<td>Jeffrey Woolford, Maj, USAF, MC, FS</td>
<td>Bags</td>
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RAM Whereabouts

RAM XV

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<thead>
<tr>
<th>RAM Graduate</th>
<th>Position</th>
<th>Unit</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maj Russell C. “T-Bone” Tontz, III</td>
<td>Chief, Aeromedical Services</td>
<td>71st Medical Group</td>
<td>Vance AFB, OK</td>
</tr>
<tr>
<td>Lt Col Niraj “JOKER” Govil</td>
<td>Chief, Aeromedical Services</td>
<td>436th Medical Group</td>
<td>Dover AFB, DE</td>
</tr>
<tr>
<td>Maj John “VILLAIN” Miles</td>
<td>Chief, Aeromedical Services</td>
<td>341st Medical Group</td>
<td>Malmstrom AFB, MT</td>
</tr>
<tr>
<td>Maj Matthew “SNIPEr” Ramage</td>
<td>Chief, Aeromedical Services</td>
<td>354th Medical Group</td>
<td>Eielson AFB, AK</td>
</tr>
<tr>
<td>Maj Angela “VETTE” Albrecht</td>
<td>Commander</td>
<td>412th Aerospace Medicine Squadron</td>
<td>Edwards AFB, CA</td>
</tr>
<tr>
<td>Maj Karen “Skim” Rupp</td>
<td></td>
<td>Wright State Family Practice Residency</td>
<td>Dayton, OH</td>
</tr>
<tr>
<td>Col Joseph “The Count” Connolly, III</td>
<td>Commander</td>
<td>9th Aerospace Medicine Squadron</td>
<td>Beale AFB, CA</td>
</tr>
<tr>
<td>Lt Col Marie-France “POTS” McIntee</td>
<td>Commander</td>
<td>31st Aerospace Medicine Squadron</td>
<td>Aviano AB, Italy</td>
</tr>
<tr>
<td>Col Hugh “MORPh” Mulagha</td>
<td>Commander</td>
<td>55th Aerospace Medicine Squadron</td>
<td>Offutt AFB, NE</td>
</tr>
<tr>
<td>Maj Danny “Popeye” Pizzino</td>
<td>Chief, Aeromedical Services</td>
<td>47th Medical Group</td>
<td>Laughlin AFB, TX</td>
</tr>
<tr>
<td>Lt Col David “Meister” Andrus</td>
<td>Commander</td>
<td>52nd Aerospace Medicine Squadron</td>
<td>Spangdahlem AB, Germany</td>
</tr>
<tr>
<td>Maj Richard “MOFIA” Kipp</td>
<td>Chief, Aeromedical Services</td>
<td>88th Medical Group</td>
<td>Wright-Patterson AFB, OH</td>
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Reflections on the Candy Bomber this Christmas

Kevin “Moses” Hettinger, Lt Col, USAF, MC, SFS
RAM XVI

This Christmas, my wife bought our children a book entitled Christmas from Heaven, the True Story of the Berlin Candy Bomber, by Tom Brokaw. Since meeting Ret. Col Halvorsen while stationed at Ramstein AB, Germany, we have felt a connection to this story and have made its retelling part of our family Christmas tradition. My kids love hearing how little parachutes filled with candy floated to the waiting arms of hungry children. But this story is both endearing and timeless because an average person brought light to those who had been surrounded by darkness.

Everyone needs hope today as much as the West Berliners needed it then. Hope is a universal need. Transport aircraft, and the airlift they provide, deliver hope to the unfortunate around the world who are oppressed by man or nature.

My experience on the airlift taught me that gratitude, hope, and service before self can bring happiness to the soul when the opposite brings despair.

— Taken from IMPRESSIONS OF A BERLIN AIRLIFT PILOT
Gail S. Halvorsen, Col USAF (Ret)

Maybe this wonderful and true story can become part of your holiday tradition. The following is an account from the Hill AFB Fact Sheet “Berlin ‘Candy Bomber’.”

One of the many American pilots to fly the USAF C-54 Skymaster during the Berlin Airlift of 1948-49 (“Operation Vittles”) was Colonel Gail S. Halvorsen of Provo, Utah. During the operation he became known as the “Candy Bomber” because he repeatedly dropped candy to German children from his aircraft on approach to the runways.

The idea grew out of a chance meeting between Halvorsen and several German school children at the perimeter fence of Tempelhof Airport. While waiting for his aircraft to be unloaded one day he decided to walk to the end of the runway and photograph other C-54s making their landing approach to the runway, a tricky descent over several buildings outside the Tempelhof grounds.

While standing at the barbed wire fence he struck up a conversation with the German children gathered outside to watch the giant airplanes land. The hungry children asked if Halvorsen had any gum or candy, and he eagerly gave them two pieces of gum that he happened to be carrying in his pocket. He promised to bring them more gum and candy on his next flight into the airport, saying that he would drop it to them as he passed over them while landing. When asked how they would know which of the huge airplanes was his, he said he would “wiggle his wings” as he approached their position.

True to his word, on his next mission to Tempelhof Airport, on final approach to the runway Halvorsen “wiggled his wings” and had the Flight Engineer push three bundles of sweets through the flare chute on the C-54 flightdeck. (Halvorsen had gathered the candy by talking other pilots into donating their Candy Ration Cards to the effort.) The three small parcels floated down on tiny, homemade handkerchief parachutes, but Halvorsen could not see whether the children caught the packages due to the business of landing. Later, as he taxied the empty C-54 to the end of the runway to depart the airfield, he looked to the crowd of children at the fence. Three white handkerchiefs waved back at him enthusiastically!

Over the next few weeks Halvorsen repeated the airdrops to an ever-growing audience of German children at the fence. Soon he even began to receive letters at the airport, addressed simply to “Uncle Wiggly Wings — Tempelhof,” requesting special airdrops at other locations within the city! Local newspapers picked up the story and his fame began to spread. Back at his home base Halvorsen began to receive mail from other pilots who wanted to help. Candy was donated, handkerchief parachutes were made by volunteers, and the tiny parcels began to fall all over Berlin.

On a brief trip back to the United States Halvorsen was asked by an interviewer what he needed to continue his popular “Candy Bomber” operation. He jokingly remarked “boxcars full of candy!” Sure enough, shortly after his return to Germany a train car loaded with 3,000 pounds of chocolate bars arrived for “Uncle Wiggly Wings.”

Thousands of pounds of candy continued to arrive from the United States to support the airdrops. Other pilots volunteered to drop the packages of sweets across the city. After several letters were received from East Berlin “Uncle Wiggly Wings” even made a few drops to school yards there, angering Soviet officials for the “attempted subversion of young minds.” When asked about it Halvorsen commented “kids are kids everywhere.” He even mailed packages of candy to disappointed children who wrote to say they had never been able to reach the “sweet gifts from the sky” before others got all the loot. No one was to be missed by Utah’s “Candy Bomber.”

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