President’s Column

Rob “MOBBIC” York, Col, USAF, MC, SFS
President, Society of United States Air Force Flight Surgeons

Welcome to the summer edition of FlightLines. This issue is jam-packed with some heavy hitters who impart their perspective on leadership. As a prelude, let’s contrast the differences between management and leadership.

Management is the allocation of scarce resources against an organization’s objective, the setting of priorities, the design of work, and the achievement of results. Most important, it’s about controlling.

Leadership focuses on the creation of a common vision and the motivation of people to contribute to the vision and encourage them to align their self-interest with the organization. It’s persuasion, not simply commanding.

In the book *On Becoming a Leader*, Warren Bennis delineated the differences:

- The manager administers; the leader innovates.
- The manager is a copy; the leader is an original.
- The manager maintains; the leader develops.
- The manager focuses on systems and structure; the leader focuses on people.
- The manager relies on control; the leader inspires trust.

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• The manager has a short-range view; the leader has a long-range perspective.
• The manager asks how and when; the leader asks what and why.
• The manager has his or her eye always on the bottom line; the leader’s eye is on the horizon.
• The manager imitates; the leader originates.
• The manager accepts the status quo; the leader challenges it.
• The manager is the classic good soldier; the leader is his or her own person.
• The manager does things right; the leader does the right thing.

So, a leader is the top echelon of the Air Force Medical Services hierarchy… the Surgeon General, AFMSA, or MAJCOM staff, right? As a lowly base-level flight doc, I can save myself time and stop reading now. Clearly this doesn’t apply to me. WRONG!

In this issue, Lt Gen Robb discusses how subordinate actions support the presidential lines of effort (LOE). From the Joint Chiefs of Staff, down to the individual Airman, we all align our efforts to support the larger mission. You may think, “Gee, then POTUS is the leader; therefore, my leadership is superfluous.” Where your role as a worker bee or manager is certain, your current station does not alleviate you from the obligations and responsibilities of leadership.

In Lt Gen Travis’s article, he reinforces the concept of service before self as a leader. Regardless of where or what you are assigned, your challenge is to take your leader’s vision and apply it to your area of responsibility. Don’t just manage programs and subordinates; form a vision and inspire those to follow. It is easy to sit back and be a victim of the machine, but by applying service before self in addition to understanding the strategic and operational visions of our leaders, we can lead by improving our processes and optimize our LOE to support.

Finally, in Lt Gen Ediger’s article, he discusses the Air Force rollout of the new Base Operational Medical Cell. This program overhauls how the AFMS will deliver operational medicine and will provide a plethora of leadership opportunities, bearing in mind the principles of LOE and service before self.

I hope you enjoy this issue and apply these pearls to hone your skills as leaders in the United States Air Force. As a final shot, I want to encourage each of you to complete your grade-appropriate Professional Military Education. These courses will give you a better understanding of the Air Force and National strategy and are critical in your development as an informed Air Force leader.

Leadership permeates throughout the organization, regardless of rank or position. Embrace leadership opportunities. Simply Lead! 

From the Past President

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

Leadership – Just Do It!

Greetings again, flight docs, for my final time. Hard to believe this is my last column. This year has passed seemingly in afterburner. And actually, now looking back, the past 30 years moved pretty briskly, too. Being your president was an amazing capstone to my 30 years in the USAF.

Many of you already know that I retired on 1 July. The photo here is of my fini-flight with Randolph’s 99th Flying Training Squadron. My wife and oldest daughter were there to celebrate. The “Coke bottle” is a tradition linked to the heritage of the original Tuskegee Airmen 99th Pursuit Squadron’s first enemy kill. There are lots of Airmen stories like this for you all to participate in, if you actually get out of the clinic! Go experience this rich military history.

By now, you may be tired of my challenge to you, but now more than ever, it is vitally important that each of you 1) advance Aerospace Medicine (AsM), 2) recruit and retain more flight surgeons and AsM specialists, and 3) foster continuing professional development and leadership, particularly within our enlisted force, the 4N0X1-F technicians. To that end this edition is focused on leadership… your leadership, formal or informal, as a physician, as a medical team leader, as an officer, and a commander.

We spared no expense for this edition. I’ll call it the “9-star” edition. There are awesome perspectives from three top flight docs of recent history – T2, Drugs, & Pappy. Drs. Tom Travis, Doug Robb, and Mark Ediger are all USAF Lieutenant Generals of current and recent fame. And just for you SoUSAFFS folks, they have put together some awesome words (even though I had to coax them just a bit J). Without a bit of coaching (J), they came up with great insights into leadership from three distinct vantage points, the individual physician perspective, the USAF & AFMS perspective, and the overall Joint perspective. Soak these words in; we may not have this level of flight doc leadership for a while.

And I’ll just have to add that leadership doesn’t stop there. U.S. Medicine (and perhaps global medicine as well) is at an interesting time. While medicine claims to value preventive care, it is based largely on episodic clinical diagnostic events. And as I mentioned in the spring edition last year, Preventive Medicine is the “one percent” of medicine, not the richest “one percent” but the only percent that is trained outside of that paradigm with a population perspective. I contend that the next phase of development in U.S. Medicine is the transition to an overall individual Health and Human Performance focus.

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And USAF flight docs (ok, could be all military flight docs) are the only group of physicians who actually practice the kind of medicine that leads to better health and performance. This is why our patients love Flight and Operational Medicine. And this is ultimately why my charge to you [1] advance AsM, 2) recruit and retain more flight surgeons and AsM specialists, and 3) foster continuing professional development and leadership is so critical, not just for the USAF but for medicine to actually develop the mindset required to move to that next level, out of the illness realm and into the prevention realm. Granted the money system will have to change, but patients desire it. And that will keep driving the transition to better health and care based on performance outcomes.

Speaking of transition, leadership happens to be a critical portion of the USAF SG’s BOMC rollout. Yikes! Painful, I know. But keep reading. This edition has both the AFMSA perspective by Joyce Fiedler and a parting shot from Dr. BOMC X, Colby Uptegrafft. You’ll get more than a couple of chuckles out of his work.

Hanky, the new consultant, took #2 of my charge to a whole new level. So get on it. De-Mo mixes in a great perspective on leading from the base level, and how it can impact the entire force. And for those of you who didn’t know, props to De-Mo for taking this year’s Space Medicine Association’s Young Investigator’s Award. Check it out! http://spacemedicineassociation.org/young-investigator-award/. Ferri gives us the latest words on the pilot-physician program, another great way to lead in the AFMS. The last leadership piece is Doom’s final installment on Flight Surgeon wings, describing with “the Classics” our profession’s rise and fall (and perhaps rebirth) within the USAF.

And for your lagniappe this edition, we have an orientation to the Neuropsych Branch of the ACS and advice on how to engage them for your operators. Hope you enjoy the entire edition. And give it to two other flight docs you know!

It has been a wicked fast presidential year and truly an amazing way to wrap up a 30-year USAF career. It’s been my honor to serve in the world’s greatest Air Force. Thank you for the honor of serving you and the Society. Good luck to your 56th President, Dr. Robert “MOBBIC” York. Remember: Lead your folks. Support the mission. And above all, keep ‘em flying… and operatin’. Bugs out.

SoUSAFFS Membership and Merchandising Updates

We wish to congratulate and welcome the two new commands of the membership and merch team: Lt Col Stefanie “Phantom” Watkins Nance (membership chair) and Capt Ashley “Blue” Franz (merchandising chair). These two highly skilled, young RAM 2017s are excited to serve and make our program run even more smoothly! As always, we thank you for your patience during this transition time.

We have recently updated our online store for your convenience, so stop by and pick up your Mishap Handbook or Flight Surgeon Checklist today! These items, as well as RAM patches and RMOs, are also available for purchase at the annual AsMA meeting.

To update your society membership or contact information, please visit www.sousaffs.org, login, and select “Edit Profile.” Your dues can be paid by PayPal or mailed to our P.O. box. For any questions or concerns regarding your membership, please contact us at membership@sousaffs.org.

The views expressed in this newsletter are those of the individual authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.

From the Editor

Chris “VADER” McLaughlin, Capt, USAF, MC, FS
RAM XVII

Summer brings many changes for the AFMS. There are new residents, brand new flight surgeons, new assignments, and a new editorial staff for FlightLines. While the editors of FlightLines are temporary, one element remains unchanged: the staff is always drawn from the class of RAMs. Why is this important? In addition to producing aerospace specialists, the RAM produces some of the finest leaders within the AFMS. One need only look through the table of contents of this very issue to see evidence of RAM leadership. We are fortunate to have lessons in leadership from RAMs Lt Gen Ediger, Lt Gen (ret) Robb, and Lt Gen (ret) Travis.

In addition to pearls from the highest levels of USAF and DoD leadership, this issue spotlights leadership and innovation from the “boots on the ground.” Herein lies the importance of SoUSAFFS. We as flight surgeons are uniquely developed to appreciate our role in the greater mission of the DoD. Our community is small, but it is of immeasurable importance to our country. SoUSAFFS and FlightLines provide us an opportunity to engage with one another. We will continue to face changes such as the emergence of RPAs, BOMC, and a myriad of other challenges heretofore unconsidered. It is our responsibility as flight surgeons to remain on the front lines and work together to make one another better. As noted in the Flight Surgeon Oath, “what I learn and practice may turn the tide of battle.”

Change and leadership. They are part of the bedrock of flight medicine. As I take the editorial reins from Lt Col Kevin “Moses” Hettinger, I thank him for his leadership over the past year. He has put together a very valuable newsletter and modelled what it means to be a RAM and leader. I am sure I am not alone in wishing him luck in his next adventures.

For all of us, let’s ready ourselves for whatever challenges may present themselves and continue to be the leaders that flight surgeons have always been.

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To update your society membership or contact information, please visit www.sousaffs.org, login, and select “Edit Profile.” Your dues can be paid by PayPal or mailed to our P.O. box. For any questions or concerns regarding your membership, please contact us at membership@sousaffs.org.
Well, it’s not San Antonio, and from the looks of that Beltway it must be somewhere near DC. Yes, you guessed it, the Aerospace Medicine Consultant is now located at AFMSA within DHHQ at Falls Church, VA. It has been quite a summer of moves, and I would be remiss without sending a big shout out to MOBBIC for leaving the state of the flight surgeon better than he found it 3 years ago!

Now, a big shout out to all of you…it’s not too soon to reach out to me about your future plans. As always, we need motivated FSs to step up into the SGP role. We will have many openings this next summer cycle, and for those experienced FSs out there who are not RAMs but would like to take on the responsibility of leading a base level Team Aerospace, we need to talk! We would like to identify and recruit those FSs who may not have thought about being an SGP. If you worked as an appointed MTF SGP for at least a year filling in while the assigned SGP was gone, this should be on your horizon. If you are already serving as a flight commander in a flight medicine clinic and are vulnerable to move this next year and want to talk about future opportunities, we should talk. If this describes you and you are interested in taking the next step of leadership in our field, please contact me at patricia.a.macsparran.mil@mail.mil. But don’t worry; contacting me does not obligate you to serve as an SGP.

With your help over these next several years and with the cooperation of AFPC, we are working to balance your clinics. We want to make sure you have real mentoring opportunities. As we visit bases and get feedback from you and commanders, there are too many bases where everyone is just starting out and learning how to be an FS, let alone being able to mentor new FSs who are interested in joining the field. Now, for those RAMs out there, I already know who you are, but we still need to talk...sometime this fall. So, if I haven’t already reached out to you by the end of September, please reach out to me!

This should be no surprise to you, but WE NEED FLIGHT SURGEONS! You remain our most valuable recruiter. Talking to your peers and sharing our unique mission and opportunities are the best recruiting tools we have. Many of these conversations have led your civilian peers and colleagues to call us for more information and ultimately to a career in the AF. When you go home, visit your old campus and talk to young, prospective students and residents. It will make you feel good to give back and people appreciate the opportunity to pick your brain about your own experiences.

Over this next year, I’ll be dropping in to several bases. There is no need to wait for me to show up at your base to have a conversation. If you missed the BLUF...we need to talk! Lt Col (sel) Lewis Taylor at AFPC is working very hard with me to execute FS assignments and level the field for FSs across the AF. Continue to always do your best, execute the mission, and do the right thing. We provide care for an amazing community who thinks the world of your expertise as you ensure continued mission capability! Now...GO RECRUIT SOME FLIGHT SURGEONS! 🎯

Reflections of the AsMA Annual Scientific Meeting
April 22-29, 2016; Atlantic City, NJ

Kevin “Moses” Hettinger, Lt Col, USAF, MC, SFS (Outgoing Executive Editor)
RAM XVI

The conference was held at Harrah’s Resort, Atlantic City, NJ. While Harrah’s Entertainment, Inc. is one of the most recognized names in the casino gaming business, Harrah’s traces its roots to a small Reno bingo parlor, owned and operated by William Harrah. William Fisk Harrah was the son of a Venice, CA, lawyer and real estate operator. The senior Harrah went bankrupt during the Depression and was left with only one asset: a leased building on the honky-tonk Venice pier jutting into the Pacific Ocean. Here he operated a nickel-and-dime game of dubious legality, loosely based on bingo, in which players sat in a circle and rolled marbles toward a number. After Bill Harrah was caught cheating on a college chemistry exam in 1930, he went to work running the game and soon concluded he could do better than his father, who sold it to him for $500. He got rid of the shills his father had hired, refurbished the premises, and grossed as much as $50,000 a year. In the wake of a state crackdown on gambling, Harrah moved in 1937 to Reno, NV, where gambling had been legalized 6 years earlier. There he bought a bingo parlor that was located too far from the action and failed in 3 months. In 1939, however, he reopened in the two-block gambling heart of Reno. Three years later he opened a casino, equipping it with a blackjack and a craps table and 20 slot machines and the enterprise flourished during the free-spending World War II years. (http://www.referenceforbusiness.com/history2/4/Harrahs-s-Entertainment-Inc.html).

Any idea what the name “Harrah” means? According to babynamespedia.com, Harrah comes from Sanskrit roots and means a “seizer,” one who takes hold suddenly or forcibly (www.freedictionary.com). One could clearly argue that William Harrah “seized” the business opportunity afforded him, turning a small-time gaming outfit into an entertainment icon.

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This year’s AsMA theme was “Human Performance and the Year of the Aerospace Medicine Professional.” As Aerospace Medicine Professionals, ours is the challenge to seize opportunities for excellence despite the formidable environments in which we and those we serve live and work. Presentations across the key categories of human performance, clinical medicine, travel & air transport medicine, space medicine, and safety paid tribute to the breadth and complexity of Aerospace Medicine while highlighting steps forward in each arena. The 62nd Louis H. Bauer Lecture was given by Lt Gen (ret) Douglas Robb and entitled “Aerospace Medicine: Adapt or Perish.” He described aviation advances in a historical perspective and championed recent successes in aeromedical evacuation, CASEVAC, space, and civil aviation. The 3rd Eugen Reintertz Memorial Lecture was given by CAPT (ret) Frank Butler and entitled “The Top Ten Lifesaving Advances in Aeromedical Evacuation from 14 Years of Conflict.” Advances that made the list ranged from the tourniquet, a small device in the hands of medic and non-medic at the point of injury that has saved countless lives, to the CCATT (Critical Care Air Transport Team), which has worked to safely transport intensive-care-level casualties in flight to higher echelon care.

Finally, I’d like to recognize a few of us who epitomize the concept of the Aerospace Medicine Professional and excellence in Human Performance—the SoUSAFFS annual award winners.

- Malcolm C. Grow Award: Capt Paul DeJulio (ACC)
- Operational Flight Surgeon Safety Award: Capt Mitchell Radigan (AFSOC)
- Team Aerospace Award: Hurlburt Field (AFSOC)
- Olson-Wegner Award Airmen: SrA JaCori Owens (AETC)
- Olson-Wegner Award NCO: TSgt Mark Villano (AFSOC)
- Olson-Wegner Award SNCO: MSgt Matthew Warters (USAFE)
- Howard R. Unger Award: Maj John Miles
- Julian E. Ward Memorial Award: Lt Col Stephanie Davis
- George E. Schafer Award: Col Hernando “Bugs” Ortega

In conclusion, it has been a pleasure to serve as the FlightLines Executive Editor this past year. As I now graduate from the RAM, I will turn over the reins of this position to one more capable than me, Capt Chris “VADER” McLaughlin. I would like to thank Bugs for his energetic leadership and example of professionalism and Ms. Sandy “OCD” Kawano, whose attention to detail and organizational skills far exceed that of her referenced call-sign and without whom FlightLines just would not happen. I look forward to reading of your continued accomplishment in future FlightLines and seeing you in Denver next year.

**SoUSAFFS Merchandise**

We are currently in the process of reorganizing and revamping our merchandise inventory and online store, but rest assured that both the Mishap Investigation Handbook and Flight Surgeon’s Checklist are the most updated versions available. Thank you for your continued patience with our merchandise sales department – it is our aim to keep you armed with the tools and gear to keep you on top of your flight medicine game!

**COST:**
The Aircraft Mishap Investigation Handbook and the Flight Surgeon’s Checklist are $45.00 each.

**S&H:**
- Under $54.00: Add $8.50
- $55.00 - $100.00: Add $12.50
- $101.00 - $150.00: Add $15.00
- $151.00 - $250.00: Add $17.50
- $251.00 - $350.00: Add $27.50
- Over $350.00: Add $37.50

**HOW TO ORDER:**
- **Online ordering:** The PayPal account is working, but you may also use cash, check, or money order payable to “SoUSAFFS” or “Society of United States Air Force Flight Surgeons.”
- **Snail mail ordering:** Mail your written request for the type and quantity of either resource you choose to order and include your check for $45.00 for each resource plus the appropriate additional S&H cost according to the above table. Send your order to:
  
  SoUSAFFS
  P.O. Box #1776
  Fairborn, OH 45324

Please allow some turnaround time for orders; there are often minor delays due to TDYs and manning constraints.

Orders can be followed up through our merchandising officer Capt Ashley Franz at ashley.franz@us.af.mil.

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FlightLines: Vision and Mission

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

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

FlightLines: Vision and Mission

Flight Surgeons, have you joined SoUSAFFS yet? The Society of Air Force Flight Surgeons is a constituent organization of AsMA that more specifically supports the needs of AF Flight Docs, with a focus on education, mentoring, and networking. We are reaching out to our cadre of young physicians to make our organization one that is essential to be a part of. Not only will SoUSAFFS membership afford you invaluable networking opportunities, but it will also make you eligible for retreats/trips to other bases to experience other missions/airframes and bond with your fellow Flight Docs! There’s even better news…you no longer need to be an AsMA member to join SoUSAFFS*, and instead you pay only $20 annually. We want to grow our organization, and we can’t do that without bright ideas from excited young docs! Join us today at www.sousaffs.org.

For more information, please contact Capt Brooke Organ at brooke.organ.1@us.af.mil.

*If you are a non-AsMA member of SoUSAFFS, you are ineligible to vote in AsMA elections.

HELP SoUSAFFS GROW!

Notice!

Call for Content

What makes FlightLines great is that it connects us with the rapid changes and variety of expertise that exist in USAF flight medicine. Send us news that affects us all, teach us about your area of expertise, and share with us your “There I was…” stories from the field. (Include your pictures!)

Submission guidelines:
500-3000 words
Pictures 300 dpi or better in .tif or .jpg

Send your articles, news, suggestions, or comments to:
christopher.mclaughlin.11@us.af.mil
andrew.timboe.1@us.af.mil

Information Update!

Moving, need your FlightLines sent to another email address?

1. FlightLines distribution email update—Send to christopher.mclaughlin.11@us.af.mil

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As we move through this summer of 2016, I appreciate this opportunity to greet our flight surgeons. I know summer is a time of transition, with some moving and others seeing to the mission at home or away. I hope those of you at home this summer were able to enjoy some time off with family.

I am visiting some USAFE missions as I write this. The strong work this summer in response to crises in Turkey, Syria, and Sudan has demonstrated the importance in today’s world of agility and adaptation in air power. Ready, proficient medical support is key to our Air Force’s agility and adaptability.

Our Air Force is steadily evolving in capability. Likewise our medical capabilities evolve in pace with the mission and also in pace with new medical knowledge. With this comes complexity. Combat roles now fall to an expanding circle of Airmen of all ranks and a widening variety of skill sets. The performance of individual Airmen is becoming increasingly important as technology and tactics adapt to new threats. Mission expansion and areas of diminished retention have stretched certain skill sets to the extent that the Chief of Staff of the Air Force has raised serious concerns about readiness, with pilots and aircraft maintenance as primary examples.

In Air Force Medicine, we must help our Air Force build its readiness and meet growing demands for its capabilities by improving our processes in operational medicine. An Air Force audit performed in 2015 told us we need to improve the accuracy and timeliness in various aspects of our support to unit commanders and their Airmen. This includes processes pertaining to managing duty limiting conditions, medical evaluation boards, and preventive health assessments.

We know we need to posture our teams throughout the Medical Group for success to attain sustained improvement in operational medical support. Our focus is on resetting teams and processes in a way that will make them more reliable and sustainable.

This is where we need the knowledge and leadership of our flight surgeons. You are experienced in direct support to operational commanders and their Airmen. We started the Base Operational Medical Cell in Flight Medicine because you and your Senior NCOs are the right leaders to guide change in this essential realm of our mission. The fidelity you bring to this implementation and your innovative thought will enable adjustments and broader application in support of all commanders and every Airman.

I know this is challenging work, particularly as we scan records for overlooked health issues from the past. I believe the focused efforts now will pay dividends to the mission. We need your observations and ideas as we move forward.

I've enjoyed meeting many of you in my initial year as Surgeon General and look forward to meeting many more of you in the months ahead. Please accept my sincere thanks for your dedication and leadership.

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BOMC – Not Just Another Four-Letter Word

Joyce P. Fiedler, Col, USAF, MC, FS

Unless you’ve been living under a rock since January 2015, you may have heard the term “BOMC” once, twice, or incessantly, ad nauseum, and undoubtedly in the subject line of multiple weekly (or perhaps daily) emails from HAF SG3P. For those of you still in the denial phase and in the spirit of standardization, let’s start at the beginning.

The Base Operational Medicine Clinic (aka BOMC) is the first rollout of the USAF Surgeon General’s vector for the Air Force Medical Service of tomorrow – the Air Force Medical Home (AFMH) 2025. The CONOPS was released in January 2015. Implementation plans specific to BOMC followed in December 2015. AFMH includes Human Performance Integration, Trusted Care, and a player to be named later. Just kidding…I wanted to see if you are still paying attention.

The three pillars of BOMC (not really pillars but three sides of a triangle) are Leadership, Standard Work, and Continuous Process Improvement. These concepts were not developed in a vacuum – they are processes rooted in industry, now spreading across the civilian medical sector. Together, these fundamental concepts will drive us toward a culture of quality and safety. BOMC is the flightpath of the Aerospace Medicine Enterprise toward trusted care – high reliability and medical standards.

Leadership – it’s time to do more than talk the talk – leadership WILL (note that I did not use Can, Should, or May) permeate from the top down. Leadership starts with You, MAJCOM SGPs, and next in line You, MTF SGPs. It is your responsibility to ensure the execution of this SG-directed program. We need you to be excited about BOMC and to embrace it. Joe Airman will see that and will follow your lead.

Continued on page 8
As well, leadership will flow from the bottom up – the BOMC Medical Director and the BOMC Team Lead will lead the charge, ensuring that daily huddles are performed, training is completed in a timely manner, and workflows are followed. Checkrides and quality audits will become routine – shamelessly stolen from the aviation arena, but highly effective.

Next up – Standard Work. Now please don’t tell me that medical care in the AFMS is working just fine – it just plain ain’t. We’ve got 75 MTFs interpreting AFIs 75 different ways. The result? Jane Airman PCSes and spends the next 2 months saying, “But we did it this way at my last base!” And the service member with multiple PCSes under his belt has a diagnosis or two that may be disqualifying for continued military service, should have a profile but doesn’t, has not completed a fitness test in over 2 years thanks to an ankle injury that magically re-appears 1 week before the test, and so on and so on. You get my point.

An extensive record review, albeit painful, will check these missteps. At the end of the day, it’s all about doing the right thing for the patient. Workflows and algorithms are not cookbook medicine; they represent medicine in 2016 and the wave of the future.

Finally – Continuous Process Improvement. Gone are the days when the good idea fairy lands 6 months prior to an inspection. Whenever a BOMC team comes up with a more efficient process, there is a standard form (the Change Request Form) that is vetted up the chain. Once approved, the change is tested and, if successful, released for widespread use across all 75 MTFs.

What will BOMC look like when all is said and done? BOMC will function as an operational specialty clinic where all occupationally related functions, including PHAs and separation exams, will be accomplished. At the end of the day, primary care clinics will be solely responsible for the primary care needs of their empaneled beneficiaries. What a novel concept! Ladies and Gentlemen, dust off your stethoscopes.

In all seriousness, we recognize that culture change is slow and tedious. I am confident that we will get there. And it starts with YOU.

The Keesler BOMC X: Fighting for Innovative Culture Change in a Bureaucracy

Colby Uptegraft, Capt, USAF, MC, FS
Resident Physician, General Preventive Medicine

With intern year, the Aerospace Medicine Primary Course, and the long, tedious initial credentialing process in the rearview mirror, I spread my young Flight Surgeon wings at Keesler in October 2014. The Keesler BOMC clicked “on” the same month with the use of the PDF templates everyone is now experiencing across the Air Force. The legacy process means nothing to me. I’ve never done an “old” Preventive Health Assessment (PHA) or flight physical, but having consumed (and distributed) the BOMC Kool-Aid for the past 2 years, I believe in the BOMC potential.

For those of you who kept reading after that last statement, let me explain. I don’t like performing PHAs or clearances. While mandatory for us to perform, they seem to be a lot more work than they’re worth. When they do provide value, they’re reactionary to deficits in standard of occupational and preventive medicine care by the PCM. Basically, they’re plugging holes in our information systems and PCM business practices. Unfortunately, we have holes. Our poor information systems, time-constrained PCMs without proper occupational and preventive medicine training, and lack of standardization across the AFMS enterprise provide a perfect alignment of the holes in the Swiss Cheese Model. Members with disqualifying conditions are bound to slip through. Additionally, our obsession with and oversimplification of applying checklists to medicine causes us to “pencil whip” processes just so we can be “green” on a metric board.

We exposed this false positive Individual Medical Readiness (IMR) green rate at Keesler. If our findings at Keesler extrapolate to the rest of the Air Force, then IMR numbers could be 10% lower than current projections. That’s 30,000 Airmen with potentially disqualifying medical conditions who could be mistakenly deployed, compromising their health and the mission. Like it or not, the BOMC exposed these missed medical conditions. While I’ve heard countless complaints about the BOMC implementation, some coming from myself, the value is real.

More than the direct effects, the BOMC, along with Trusted Care, is trying to change the culture of the Air Force Aerospace Medicine community and the AFMS. Many of you have heard of the Toyota Production System (TPS), and some of you have read about it. I doubt the naysayers will object to the tenets of TPS. The BOMC is the start of the TPS concept within Air Force Medicine and hopefully the Air Force at large. Instead of the traditional top-down approach to programmatic implementation, it’s trying to empower the A1Cs, captains, and individual clinics as agents of change. We’re the subject-matter experts, the end-users. We’re the workers who directly interact with patients every day. If you’ve found a better way to operate (and maybe it only saves a few minutes), then share it up the chain. A few minutes at your base could be hundreds of hours across
The views expressed in this newsletter are those of the individual authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.

One of my pet peeves is hearing the quote “Flexibility is the key to airpower.” Too often this quote is used to mask either incompetence, lack of adequate preparedness, or as an excuse for last-minute, zero-value-added taskers. The quote was originally meant to emphasize “tactical flexibility,” empowering personnel at the tactical level to think for themselves. Currently it’s too often being cited after you receive several “HOT” administrative items in your Outlook inbox. BOMC is trying to empower those at the bottom, those on the business side of operations, those who actually know what is going on. Failing or succeeding, it’s at least a step in the right direction.

Knowing the negative perception of BOMC in the Aerospace Medicine community, this article was very hard to write. Just reading the title probably caused a hard visceral swallow for some. Bottom line: the BOMC is hard. Even if you believe in the founding concepts, the bureaucratic nature of our work environment seems to fight change at every opportunity. Even perfectly conceived programs or initiatives will meet resistance, and the BOMC is far from perfect, but it’s a start and a hopeful chink in our armor of tradition for the sake of tradition.

Aerospace Medicine Leadership

Douglas Robb, Lt Gen (ret), USAF, MC, CFS

Aerospace Medicine, by nature of our business, requires LEADERSHIP!

Leadership and management are not synonymous. Managers manage things. Leaders lead people.

Dictionary definition of management: organization, coordination, supervising of the activities (of a business) in order to achieve defined objectives; judicious use of means to accomplish an end; the collective body of those who manage or direct an enterprise.

Dictionary definition of leadership: a position as a leader of a group, organization, etc.; the time when a person holds the position of leader; the power or ability to lead other people.

So what do leaders do? Some say leaders motivate, they inspire, and they get folks to share in a common vision. Or leaders provide the vision and motivation to a team so they work together toward the same goal. That’s all true, but I would argue they “lead.” Leadership isn’t a noun; it is a verb. Plain and simple, it is a verb. Leaders lead… that’s what leaders do and leadership does….they lead!

“Leadership is action…not position.” D. H. McGannon

Not everyone has the courage or resolve to be a leader and take the personal or calculated risks that they may encounter; but then, not everyone is cut out to be a true leader.

“BIG TO SMALL”: Strategic…Operational…Tactical

BLUF: AMDS lines of effort (LOE) support MTF LOE, which support Wing LOE, which support MAJCOM LOE, which support Air Force LOE, which support CICS LOE, which support DoD LOE , which then support the President’s LOE (National Security Strategy).

You get the picture. At the end of the day, what we do each and every day in AMDS supports the “mission.” We are often tactical execution in support of operational requirements that support strategic objectives. And the soonest you as a leader, whether you are a squadron flight doc or a MTF commander (some say that might be too late!), figure that out, the better. That is why it is critical that “medical” understands how we fit into the toolbox of garrison care, training, operational, contingency, and combat support environments. We are not an end, but a means to an end.

By nature of our aerospace medicine training (if USAFSAM and RAM mentorship are doing their jobs!), flight docs and RAMs should get the “Big Picture” of mission support and not how only aerospace medicine, but all of medicine-in-general, fits into that equation. We should, at an early stage in our careers, begin to build on our own leadership capability that best prioritizes resources (as we all know, there are NEVER enough resources to go around) and learn when and how to take tactical, operational, and strategic risk as we progress up in AFMS and Joint leadership positions. The best tactical decisions are made when one has an understanding of the operational and
I’m told that one of Bugs Ortega’s goals in FlightLines this year is to discuss why flight docs fly. I can personally come up with a pretty good list, and it’s not all, “because it’s cool to fly Eagles/Vipers,” or “tanker crews cook awesome breakfasts on cross countries.” Those things are true, but there are more operationally relevant issues as well. In my experience with the 114 FS at Kingsley Field ANGB, I found that the more time I spent with the pilots on the ground and in the air, the more invested I became in their well-being. The more invested I became, the more I wanted to figure out ways to help them. So what are ways we can make life better for aircrew? The answer is, of course, “it depends.” It might be a house call, some advice over the phone about an ill family member that you give when you are on leave, or any of a thousand examples of low hanging fruit that you and I can come up with. But some fruit does not hang so low. When it comes to changing how Big Blue does business, it takes thought, preparation, patience, building relationships, and the will to endure to effect change. And the outcome is anything but certain, so you’d better have a lot of gas in the tank when you start that journey. Your supply of gas is the people you’re fighting for. Can you, the operational flight doc in the field, impact AFMS doctrine? I’m going to try to convince you that you can and you should. I hope you won’t think I sound hypoxic by the time I finish.

Sometimes we want to change doctrine because the existing rules don’t suit us. Maybe we think there’s too much paperwork. I am fine with anyone who pushes a change through that makes our lives less administratively burdensome. Other times, it’s more altruistic. Call it a gap analysis; we see something that needs to happen to take care of the guys and then figure out how to make that happen. But that can be intimidating. The institution has a lot of inertia, and getting it to change is no easy task. The litany of “we’ve always done it this way/you’ll have to get that cleared through…” mission NOT accomplished. And that pressure only amplifies the mindset I’m talking about. I doubt that the people who block the path to change are trying to obstructionism. Not every idea is a good one, and even if an idea is good, resources might not exist to implement it. However, some ideas just require people to think a little bit differently in order to save resources like time and money.

I am not going to sugarcoat it; it’s tough to lead in today’s operational and fiscal environment. All the more reason to take what you have learned in your clinical and operational experience to date, to include what you will or have learned in your MPH year, and apply that to how you approach the challenges that will confront your mission. You will be required (non-negotiable) to provide the highest quality care to your patients and your operators. And a precision and pragmatic approach will be required to accomplish any and all missions that you and your squadron/group/Wing/MAJCOM will be required to support in support of our Joint Force and our Nation’s objectives.

The very nature of our business in aerospace medicine demands leaders who understand resourcing and operational “triage,” who understand prioritization of mission support, and who absolutely understand what it takes to Fly, Fight, Win…in Air, Space, and Cyberspace!

Fight’s on…Team Aerospace supporting! 🚀
The USAF Pilot-Physician Program

Col Bill “Ferri” Mueller, USAF, MC, CFS
Director, USAF Pilot-Physician Program

The Pilot-Physician Program (PPP) is an exciting part of the AFMS and perfectly augments Team Aerospace’s support of operational Air Force missions. For the fifth consecutive year, the PPP will be selecting qualified flight surgeons to attend Undergraduate Flight Training (UFT) and become a pilot-physician (PP).

Medical Corps officers who are both pilots and flight surgeons have been maintaining dual qualification since the Vietnam War. However, it wasn’t until 1996 that AFI 11-405 formalized the mission, responsibilities, and procedures for the USAF PPP. Since that time, PPs have made important contributions to many high-visibility operational issues affecting multiple mission sets while maintaining qualifications in almost every USAF major weapon system, including the F-22, F-15, F-16, A-10, B-1B, B-52, C-17, KC-135, HH-60, UH-1, T-38, and T-6.

The mission of the PPP is to “provide integrated operational and aerospace medicine subject matter expertise (SME) to line and medical commanders, as well as Human Systems Integration expertise to MAJCOM Requirement Directorates and Acquisition Centers.” Similar to flight surgeons, PPs help the Line of the Air Force chain of command better understand the human issues that impact mission accomplishment and the AFMS better understand how to support these missions. In addition, PPs maintain “mission ready” qualification in their respective weapon systems and credentialing privileges at the local MDG.

By virtue of their dual aeronautical ratings, PPs provide commanders the ability to have one officer execute two missions. In a resource-constrained environment, such flexibility and efficiency is a force multiplier that optimizes communication and coordination between the local Operations and Medical Groups. Simultaneously, PPs apply a human-centric perspective to complex mission sets in peacetime or war. This human-centric view is more formally known as Human Systems Integration (HSI) and plays an important and growing role in the Air Force’s ability to plan for, acquire, sustain, and execute combat operations across air, space, and cyberspace. HSI optimizes total system performance by ensuring touchpoints across nine human “domains” are identified and optimized when a weapon system is being built, operated, or upgraded.

There are two pathways to become a PP: Pilot-to-Flight Surgeon and Flight Surgeon-to-Pilot. Most PPs start their careers as pilots and then attend medical school. While there is no formal means for the PPP to send officers to medical school, the PP Program Director can provide an endorsement for rated line officers who are requesting AFPC release them from their current career specialty to attend medical school with the intent of becoming a PP. Officers interested in pursuing this pathway must apply to medical school on their own after fulfilling academic prerequisites, taking the Medical College Admission Test, and coordinating support from their chain of command and functional assignment team. After medical school, these officers must

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serve as a flight surgeon for 1 year while applying to the PPP. In most cases, they will requalify and serve as a PP in their previous weapon system.

Since 2013, the Air Force has supported the growth of the PPP by allocating UFT slots to the PPP. This support has opened a second pathway to become a PP by which flight surgeons with at least 2 years of experience may apply to a PP UFT selection board. Flight surgeons pre-selected by the board to become PPs are sent to Undergraduate Pilot Training, Undergraduate RPA Training, or Combat Systems Officer Training, depending on the year’s allocation of UFT slots. If you are interested in learning more about this program, please visit the Pilot-Physician Knowledge Exchange site (https://kx2.afms.mil/kj/kx9/USAFPilotPhysicianProgram/Pages/PPP%20UFT%20Application%20Instructions.aspx), where you will find helpful guidance as well as important information for this year’s PP UFT selection board.

Col Bill Mueller is the Director of the USAF Pilot-Physician Program. He has been an aircraft commander and instructor pilot in the T-37, T-38, RF-4C, and B-1B. He is currently stationed at Wright-Patterson AFB, OH, and can be reached at pilot-physician@us.af.mil.

Flight Surgeon Leadership

Thomas W. Travis, MD, MPH
Lieutenant General, USAF, Retired
21st USAF Surgeon General

Greetings from San Antonio! When Bugs Ortega asked me to contribute to the FlightLines on the topic of flight surgeons as leaders, I was delighted! As many of you know, I retired in the summer of 2015 after almost 39 years in the world’s greatest Air Force. I was fortunate to fly some great jets before and after medical school, command several times at various levels, including USAFSAM and three wings, serve as MACOM surgeon twice, and cultivate a fascinating and fun career as the 21st USAF Surgeon General. I wouldn’t have missed any of it!

First, let me say this: I am proud to be a flight surgeon! The day I started drafting this article, a retired pilot from my F-15 squadron from 27 years ago sent me a note about a procedure he is having done. He started it with,” Hi Doc!” I am so proud that he still considers me as his doc! Many of you have that privilege, too. Aren’t we lucky!

I was a flight surgeon for almost 28 years, a RAM for 23 of those years, and a pilot-physician. And while I have many great memories, there is one that stands out as highly relevant to this theme of leadership. I can vividly remember an AsMA meeting in Chicago in May 1997 when the AF Surgeon General, Lt Gen Chip Roadman, was the SoUSAFFS luncheon speaker. He gave a very inspirational talk that day. You could have heard a pin drop when he said he needed leaders. In other words, don’t be complacent, try to make a difference. I felt like he was speaking directly to me. I bet others did, too. I came out of that luncheon with a new mindset. I had been very comfortable where I was and with what I was doing, but inherently I wanted to do more, and here was the AF/SG asking all of us in the room to become leaders and do more. I have credited that awakening with giving me the courage to take on new and bigger challenges that fulfilled me for the rest of my career.

Another part of the story that I frequently discuss with young cadets or officers is this: Every time you think you have a better plan for yourself than the Air Force does, think again. I can think of three distinct times in my career where I thought I knew what my next best job was – usually associated with something I wanted to do and not necessarily what the AF needed me to do. And in each case, when I was told “No, Tom, I need you to go do this instead,” I saluted smartly and went and did the job to the best of my ability and ended up enjoying the heck out of the challenge. In each of these instances, it was clearly what the Service needed from me, and in the end it allowed me to make a true difference and opened the way for even greater opportunities. That’s leadership, too – service before self.

You don’t start this evolution by proclaiming yourself a leader – that wouldn’t go over very well! You just take on more and offer to get more involved. You don’t have to be brilliant, you don’t have to be ambitious, and you can do it in your own style, comfortably in your own skin, which is the best way to stay grounded and true to your principles. But it does require some courage. I still have a copy of a “Far Side” cartoon that I cut out and carried for years, especially when I was new to command. It depicts a bloodhound on a leash out in front of a group of angry townspeople charging through the woods after someone and the dog is thinking, “I can’t smell a damn thing!” That happens. On occasion I have been at the end of the table when the team was facing a situation or problem no one anticipated, looking to me for leadership. That takes some courage. But if the team trusts you, and you trust the team and work it with them rather than simply giving orders or making demands, it becomes less daunting and even more rewarding.

So here is what I am asking of you. Simply lead. Whether you have the title of commander or not, whether you are a captain or a colonel, simply lead. Leadership requires you to step forward and be willing to take on more responsibility when called upon, or when you see that there is some way you can make a difference and no one has even asked. If you can find that within yourself, and I haven’t met many timid flight surgeons, become a leader. You, your mission, and our Air Force will benefit and I can almost guarantee you will have more fun and be more fulfilled in your career.

Thanks for what you do every day!

T2
Optimizing Your Experience with the ACS Neuropsychiatry Branch

John E. Heaton
Neuropsychiatry Branch Manager

The multi-specialty Aeromedical Consultation Service (ACS) provides comprehensive medical and mental health evaluations for military aviators stationed around the globe. The Neuropsychiatry Branch is one of the busiest branches at the ACS, in part due to our in-depth comprehensive psychiatry, neuropsychology, and neurology case reviews and in-person evaluations. With staff of 11, including 3 psychiatrists, 2 clinical psychologists, 1 neuropsychologist, 1 neurologist, and 4 support staff, the Neuropsychiatry Branch makes aeromedical recommendations on some of the most complex cases in the Air Force. Although we evaluate a wide variety of aviators on flying status, the number of FCII (i.e., pilots, navigators) evaluations has remained steady over time, but the number of FCIII and ground based controllers continues to grow. At our current rate of case reviews and scheduled evaluations, the Neuropsychiatry Branch will set a new record for making aeromedical recommendations in 2016.

As we all know, most cases can be handled at the MAJCOM level and do not require ACS review. However, for those cases that do require an ACS recommendation, we rely on the local flight surgeon to provide all relevant and necessary information for the case for the ACS to make a thorough and expeditious recommendation. Most cases are reviewed within a matter of days, recommending either additional information, aeroletter waiver/DQ, or in-person evaluation. Cases requiring additional information can be placed on “hold” due to needing further imaging, psychological testing, or further evaluation by a certain specialty. Other cases may be “returned” to the flight surgeon due to incomplete/insufficient information (i.e., poorly written Aeromedical Summary, missing a current psychiatric evaluation, or missing mental health records). These “Case Returns” bog down the waiver process, requiring additional work by the FS and/or mental health clinic, and ultimately delay the aviator’s potential to return to flight duties.

Below is a list of ways to optimize your experience with the ACS, specifically with the Neuropsychiatry Branch:

1. **Plan ahead…it’s in the flyer’s best interest.** Proactive planning will return our aviators to full duties as soon as possible (and minimize DNIF/DNIC time). This planning begins at the onset of treatment and continues throughout the waiver process. USAF aviators should receive optimal evaluation and treatment for their mental health conditions, which typically include utilizing either a psychiatrist and/or psychologist with understanding of aeromedical expectations and standards. This will ensure cases are not held or returned for having insufficient information or suboptimal treatment and will not delay the review or in-person evaluation, when appropriate.

2. **Get it right the first time!** The best way to ensure the most expeditious return to flight for any aviator is to submit a full and complete waiver package. To quote the title of an article in the last FlightLines issue, “Writing Waivers – Do It Right, or Do It Twice,” Col Dave Duval (AFSOC SGP) provides flight surgeons valuable information when writing waivers. In the experience of the Neuropsychiatry Branch, the number of case returns has been increasing over the years, and we’ve returned cases multiple times due to missing information (i.e., key items in the AMS, a current psychological/psychiatric evaluation, and/or complete mental health records). In an effort to provide better guidance for flight surgeons, we developed a step-by-step reference of key items the flight surgeon and mental health clinic should specifically evaluate for and include when writing the AMS. Within each chapter of the psychiatry section of the Aerospace Medicine Waiver Guide (https://ks2.afms.mil/kj/ks7/WaiverGuide/Pages/home.aspx) is our “Submitting a Mental Health Waiver Package” reference. In addition to the checklist, we’ve included a Release of Information form that the flyer can complete and sign and give to the Mental Health Clinic for coordination of the member’s record as part of the waiver package. We understand the difficulty coordinating with military, and in some cases civilian, mental health agencies, but having complete mental health records is vital for making an aeromedical recommendation to return to flying duties, regardless of case review only or in-person evaluation. Encourage the Mental Health Clinic to consult with the ACS Neuropsychiatry Branch with any questions or concerns regarding the release of the member’s records.

3. **Watch the clock…and get that waiver ready.** Demonstrated stability is necessary for waiver consideration after a disqualifying condition has been identified and treated. The mental health professional, in consultation with the flight surgeon, must decide when the aviator is back to his/her “best baseline” (and have modified risk factors for potential recurrence). This best baseline is the “start time” for demonstrated stability (regardless of ongoing treatment to include healthy lifestyle interventions, psychotherapy, and/or psychopharmacology). Typically, the ACS requires a minimum of 6 months stability for most conditions; 1 year for psychotic, somatic symptom, and eating disorders; 3 months for alcohol use disorders; and clinical judgment is required for the remaining disqualifying conditions. The flight surgeon must proactively plan ahead and prompt the mental health professional to evaluate and produce a comprehensive mental health evaluation, obtain a commander’s letter, prepare an aeromedical summary, and present this to his/her MAJCOM. Then the ACS could receive the case several months in advance of the required time for demonstrated stability and review the case early to recommend the best possible disposition, thereby returning the aviator to full duties as soon as possible. Complete documentation is essential to accomplish this task (please refer to “Submitting a Mental Health Waiver Package”). If ongoing psychotropic medications are necessary, they must be aeromedically approved (Zoloft, Celexa, Lexapro, or Wellbutrin as monotherapy within PDR dosing range). Otherwise, any other non-aeromedically approved psychotropic must be discontinued prior to the “best baseline” clock starting. Ongoing healthy lifestyle interventions and psychotherapy as needed (for additional resiliency – not simply to maintain psychiatric stability) are highly encouraged.

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We are a consultation service...consult with us through the MAJCOM. The MAJCOM is our primary customer. Talk with your MAJCOM first. However, if the MAJCOM cannot answer your question, call us (with MAJCOM concurrence). We routinely receive phone calls from flight surgeons at various stages of the waiver process who need help or clarification.

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STAMPED: “GREEN HORNET”
FINALE

Requiem of the RAM at the Foot of Oz

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

This, the final installment and chronicle to the short history of United States Air Force flight surgeon’s wings, ends much like it started – open ended, buried in moldy, smelling carbon-copied documents, and with a provocative note scribbled in a faded, tortured manner readable only to a trained classicist and scribbler of highest qualities. On the paper of its day, the following fantabulous and cryptic morphemes were written:

Requiem Sub ARIETIS Oz?
Ex antiqua alquis <unrecognizable words>
<Next 5 stanzas unreadable>
…..inscripta videntur illius;
Apellor REX Oz <unintelligible letters> Regnum;
<last 3 stanzas unreadable>

For over a year I’ve held off trying to solve this little conundrum, a scribbler’s nonsensical Latin puzzle. Getting the history together for Green Hornet seemed far richer, stimulating, and more important to my profession than trying to solve the significance of this “little note.” And yet, through pedantic discovery, time and time again, this project kept bringing me back to Latin, Greek, and sporadic quasi-classical quips throughout my research. Puzzled, I quickly and too easily concluded that that was just how medical officers of the 1950s and 1960s communicated. I concluded that big rank, big status, and even bigger words were used to crescendo or obscure contentious issues and to provide flair to an otherwise boring, bureaucratic language known all too well in government. I was wrong.

The “little note” proved too difficult for me to translate, let alone decipher, and so I decided to call an old mentor from my Colonial Farm Road days to help me understand and make sense of it all. In addition to the “little note,” I provided several other handwritten quips and quotes from the Green Hornet files that I knew the “Old Man” needed to complete his analysis. Providing anything less meant immediate scorn and raised eyebrows. Yep, he, too, was a man from the 1950s. Two months later, and at an early lunch that quickly turned into late-night dinner, the Old Man’s analysis burned through 3000 years of classical history, language, and such “fine arts and finer drink” that made the wine bill look tepid. In capturing his work – by means of content word and phrase analysis, psychological profiling, and handwriting analysis – he concluded that not one man, but two men were communicating in the lost language of the classical muse. Note: the joke I made of the lost language of the “Angels” he did not find funny. That cost me a lot. Now, the following dialogue may not be exactly what transpired between the Old Man and Pollus…err, me, but it sure…anyway, here we go.

Old Man – You come before me with a challenge. Why?
Me – I’ve come across several handwritten notes with words that I can’t read or understand.
Old Man – Hmmm, you are a grown man and you haven’t learned to read yet?
Me – Did I mention that my Conium maculatum is thriving these days?
Old Man – Pardon me?
Me – I sent and discussed with you several quotes and passages written in the language of ancient Rome, Greece, perhaps even Swahili. Tell me, what have you surmised?
Old Man – Lots. First, tell me what a requiem is or means to you.

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The views expressed in this newsletter are those of the individual authors and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
Me – A requiem is a repose of the souls of the dead.
Old Man – Good. Decay and death is a theme that has repeatedly come up in these scribblings.
Me – You mean death and rebirth, don’t you?
Old Man – Do I? One note I deciphered is a quote from Cassius Dio. The quote begins: “Our history now descends from a Kingdom of Gold to one of Iron and Rust.”
Old Man – That quote is often used to describe the decay and “death” of the Roman Empire.
Me – Ah, okay. I faintly remember my Meditations and Gibbons. And this means what??
Old Man – Two distinct hands, one Left and the other Right, duelled over the course of 9 years, from 1961 to 1970, over the value and qualifications associated with the award of the flight surgeon’s wings to both qualified and quasi-qualified medical officers.
Me – My research into Green Hornet did show a “healthy” dialogue and critique against converting Aviation Medical Examiners and Flight Medical Officers to rated Flight Surgeons.
Old Man – Both the Left hand and Right hand were passionate when it came to supporting their respective positions on flight surgeon qualifications and its chief symbol – those silver wings. It is apparent they disagreed as to who should receive the “mark” initially, but they were universal in their belief that the highest token should be earned and reserved by a group called the “Chiefs.”
Me – Ah, yes, the Chief Flight Surgeon designation. At the time it was given to the most senior of flight surgeons that had a history of over 2000 flight hours and a matching, long record of medical officer excellence that usually spanned decades.
Old Man – Anything else that distinguished them from the basic token?
Me – As of the 60s, most, if not all, of these Chiefs (C.F.S.) were graduated residents in aerospace medicine. They were called SAM RAMS – short for residents in aerospace medicine graduates.
Old Man – Stop, stop right there. Now I’ve concluded my analysis. That was the piece I needed. You were right; these scribblings were not just about decay and death, but also of rebirth and growth.

My name is Ozymandias, King of Kings; Look on my Works ye Mighty, and despair!

Me – Holy of holies, the sonnet, in Latin, of the prideful king of kings, presumably that of –
Old Man – RAMesses II from the 19th Dynasty of Egypt. And that name, RAMesses, coupled with the adjoining notations from 1 Corinthian 15:42-57, 1 Peter 1:4, and Roman 8:21 now makes sense. The title of the “little note” I initially interpreted as Requiem Sub ARiETIIS Oz?...to mean...Requiem for Ramesses the Great at the foot of Oz?
Me – I can see how that was not satisfactory. And so, what does it really mean then?
Old Man – ARIETE or arietis did not connote Ramesses the Great; instead it was meant literally to mean RAM...as in your SAM RAMS. The title of that handwritten “note” now translates to:

“Requiem of the RAM(s) at the foot of Oz?”

ME – It was a warning, wasn’t it? In Shelley’s sonnet, neglect, decay, and finally destruction had rendered Ozymandias’ once great kingdom irrelevant and ruined for all time. It was a metaphor of crushing pride and hubris associated with mankind. But what did it mean to the author of the “little note”? And why place RAM(s) at the foot of Oz?
Old Man – Medico Left and Right Hand, presumably SAM RAMS, were lamenting a decay within their ranks, the Chief Flight Surgeons, I presume, and that they were pessimistic as to the future of that preferment.
Me – And yet I detect a “but or however” somewhere about now.
Old Man – Yes, for decay and death is a natural part of the human existence, as is also birth and rebirth. I would conclude that Dr. Right Hand was pessimistic and the author of the “little note.” But did he actually place the RAM at the foot of Oz, or did he just leave it as an open question to be answered by some distant, future RAM? And as for Dr. Left Hand, with the initials C.F.S., yes, he was more optimistic. His notes included the biblical references mentioned before, and if you read them, you’ll note rebirth and resurrection consistent with biblical theology of the time.
Old Man – What are you thinking right now?
Me – I think today’s flight surgeons and RAM(s) need to assess this, our profession that is, while at the “foot of Oz,” sober and with the greatest of clarity and purpose.
Old Man – I’ll drink to that, sans Conium maculatum if you please!

Aequanimitas!
Doom Out. 🍻